CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 8SV7

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

| | PART | I - TO BE COM | PLETED BY T | HE STATI | E SURVEY AG | ENCY | Fa | acility ID: 00538 |
|---|---------------------------------------|---|---|-------------------------------|--|----------------|---|--|
| 1. MEDICARE/MEDICAID PROVIDER I (L1) 245255 2.STATE VENDOR OR MEDICAID NO. (L2) 044518500 | NO. | 3. NAME AND ADI (L3) CERENITY ((L4) 512 HUMBO (L5) SAINT PAUI | CARE CENTER LDT AVENUE | | | 55107 | 4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation | 7 (L8) 2. Recertification 4. CHOW 6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF OW (L9) | NERSHIP | 7. PROVIDER/SUF | | Y 09 ESRD | 02 (L7) 13 PTIP | | 7. On-Site Visit 8. Full Survey After Cor | 9. Other |
| 6. DATE OF SURVEY 12/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | 9/2016 (L34)(L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPICE | | FISCAL YEAR ENDING 1 | DATE: (L35) |
| 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds | 117 (L18) 117 (L17) | B. Not in Com | nce With quirements | | 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 * Code: A* (L12) And/Or Approved Waivers Of The Following Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room | | | or |
| 18 SNF 18/19 SNF 117 (L37) (L38) | 19 SNF (L39) | ICF (L42) | IID (L43) | | 1861 (e) (1) or | 1861 (j) (1): | (L15) | |
| 16. STATE SURVEY AGENCY REMAR Facility's request for a continuing w 17. SURVEYOR SIGNATURE Momodou Fatty Momodou Fatty | vaiver involving F458 | is recommended. Date: | 12/29/2016 | (L19) | | vey agency api | PROVAL Ogram Specialist | Date: 03/03/2017 |
| | PART II - TO | BE COMPLETE | D BY HCFA RI | . , | OFFICE OR S | SINGLE STAT | E AGENCY | (L20) |
| DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pa 2. Facility is not Eligible | | | IPLIANCE WITH C | IVIL | 2. (| | al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA | -1513) |
| 22. ORIGINAL DATE OF PARTICIPATION 09/13/1982 (L24) | 23. LTC AGREEMI BEGINNING (L41) | | 24. LTC AGREEME ENDING DATI (L25) | | | | | et Health/Safety |
| 25. LTC EXTENSION DATE: (L27) | A. Suspension of B. Rescind Sus | of Admissions: | (L44) (L45) | | 03-Risk of Involut 04-Other Reason f | • | OTHER 07-Provider S 00-Active | Status Change |
| 28. TERMINATION DATE: | (L28) | . INTERMEDIARY/C | ARRIER NO. | (L31) | 30. REMARKS | | | |
| 31. RO RECEIPT OF CMS-1539 | 32 (L32) | . DETERMINATION (12/16/2016 | OF APPROVAL DAT | (L33) | | 03/2017 Co. | VAL . | |
| | | | | | | | | |



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.

Cerenity Care Center on Humboldt January 13, 2017 Page 2

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



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.

Cerenity Care Center on Humboldt January 13, 2017 Page 2

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

POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / | MULTIPLE CONSTRUCTION | | DATE OF REVISIT | Γ |
|------------------------------|-----------------------|---------------------------------------|-----------------|----|
| IDENTIFICATION NUMBER | A. Building | | | |
| 245255 _{Y1} | B. Wing | Y2 | 12/29/2016 | Y3 |
| NAME OF FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CERENITY CARE CENTER ON H | UMBOLDT | 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).

| ITE | VI | DATE | ITEM | | | DATE | ITEM | | | DATE |
|----------------------|-------------------------------------|------------------------------|--------------|---------|---------------------------------|----------------------|-----------|---------------------|--------------|------------|
| Y4 | | Y5 | Y4 | | | Y5 | Y4 | | | Y5 |
| ID Prefix | F0280 | Correction | ID Prefix | F0282 | | Correction | ID Prefix | F0312 | | Correction |
| Reg.# | 483.20(d)(3), 483. ² (2) | O(k) 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 |
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| REVIEWE STATE AG | | REVIEWED BY (INITIALS) SR/KJ | DATE 01/13/2 | 017 | SIGNATURE OF S | | 2984 | | date 12/2 | 9/2016 |
| REVIEWE CMS RO | D BY | REVIEWED BY (INITIALS) | DATE | | TITLE | | | | DATE | |
| FOLLOWU 11/3/2016 | JP TO SURVEY CO | MPLETED ON | | | ANY UNCORRECTE FED DEFICIENCIES | | | | YES | в 🗆 по |

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|--|---------------------------------------|-------------------------|-----------------------------|-----------------------------|-------------------|---------------------------|------------|-----------------------------------|-----------------------------|---|---------|------------------|
| PROVIDER / SU | | .IA / | MULTIPLE CONS | | | | | | | | DATE O | F REVISIT |
| IDENTIFICATION 245255 | NUMBER | Y1 | A. Building 01 - B. Wing | MAIN BUIL | .DING 0 | 1 | | | | Y2 | 12/8/20 | 16 _{Y3} |
| NAME OF FACIL | JTY | | | | | | STREET | ADDRESS, CIT | Y, STATE, ZIF | CODE | | |
| CERENITY CA | RE CENTE | ER ON H | UMBOLDT | | | | 512 HUM | BOLDT AVENU | E | | | |
| | | | | | | | SAINT PA | UL, MN 55107 | | | | |
| program, to she corrected and t | ow those do the date suber and the | eficiencie ch correc | s previously repo | orted on the ccomplished | CMS-25 d. Each | 667, Statem deficiency | nent of De | ficiencies and fully identifie | Plan of Cor d using eith | nent Amendments rection, that have er the regulation of of each requirem | or LSC | |
| ITEM | | | DATE | ITEM | | | | DATE | ITEM | | | DATE |
| Y4 | | | Y5 | Y4 | | | | Y5 | Y4 | | | Y5 |
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| | 101 | | - | I I I I I I I I | NEDA 1 | 0.1 | | Correction | IB I ICIIX | NEDA 101 | | Correction |
| Reg. # | (101 | | Completed | Reg. # | NFPA 1 | UT | | Completed | Reg.# | NFPA 101 | | Completed |
| LSC K021 | 1 | | - 11/04/2016 - | LSC | K0351 | | | 11/04/2016 | LSC | K0920 | | 11/07/2016 |
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| LSC | | | _ | LSC | | | | | LSC | | | |
| REVIEWED BY | 1 | REVIEW | ED BY | DATE | | SIGNATUR | RE OF SUR | VEYOR | l | | DATE | |
| STATE AGENCY [INITIALS] SR/KJ 01/13/2017 | | 32984 12/8/2016 | | | | /2016 | | | | | | |
| REVIEWED BY | | REVIEW | | DATE | | TITLE | | | | | DATE | |

FOLLOWUP TO SURVEY COMPLETED ON

(INITIALS)

CMS RO

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

| | OTATE FORM. R | EVIOR REPORT | | |
|------------------------------|-----------------------|---------------------------------------|---------------|----|
| PROVIDER / SUPPLIER / CLIA / | MULTIPLE CONSTRUCTION | | DATE OF REVIS | iΤ |
| | A. Building | | | |
| 00538 _{Y1} | B. Wing | Y2 | 12/29/2016 | Y3 |
| NAME OF FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CERENITY CARE CENTER ON H | UMBOLDT | 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 for | | | | | | | | | | | |
|----------------------------|-------------------------------|-----------------------|------------|-------------|--------------------|--------------|------------------|-----------|-------------------------------|-----------|------------|
| ITE | М | | DATE | ITEM | | | DATE | ITEM | | | DATE |
| Y4 | | | Y5 | Y4 | | | Y5 | Y4 | | | Y5 |
| ID Prefix | 20565 | | Correction | ID Prefix | 20570 | | Correction | ID Prefix | 20840 | | Correction |
| Reg. # | MN Rule 4658.04 Subp. 3 | 05 | Completed | Reg. # | MN Rule Subp. 4 | e 4658.0405 | Completed | Reg. # | MN Rule 4658.052 Subp. 2 B | 0 | 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 4658.05 Subp. 2 E. | 520 | Completed | Reg. # | MN Rule Subp. 4 | e 4658.0525 | Completed | Reg. # | MN Rule 4658.060 Subp. 2 | 0 | 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 4658.07 Subp. 1 | '25 | Completed | Reg. # | MN Rule Subp. 1 | e 4658.0800 | Completed | Reg. # | MN St. Statute 144 Subd. 3 | A.04 | 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 4658.13 A.B.C | 320 | Completed | Reg.# | MN Rul | e 4658.1345 | Completed | Reg. # | | | Completed |
| LSC | | | 12/16/2016 | LSC | | | 12/16/2016 | LSC | | | |
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| REVIEWE STATE AG | | REVIEWE (INITIALS) | | DATE 01/13/ | 2017 | SIGNATURE OF | | 32984 | | DATE 12/2 | 29/2016 |
| REVIEWE CMS RO | D BY | REVIEWE (INITIALS) | D BY | DATE | | TITLE | | | | DATE | |
| FOLLOW 11/3/2010 | UP TO SURVEY C | OMPLETED | ON | | | | TED DEFICIENCIES | | | YE | s 🗆 no |
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Page 1 of 1 EVENT ID: 8SV712

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| | R / SUPPLIER / CL | | MULTIPLE CONS | TRUCTION | | | | | | | DATE O | F REVISIT |
| 00538 | CATION NUMBER | | A. Building 3. Wing | | | | | | | Y2 | 12/28/2 | 016 _{Y3} |
| NAME OF | FACILITY | | | | | | STREET | ADDRESS, CIT | Y, STATE, ZIP | CODE | | |
| CERENIT | TY CARE CENTE | R ON HU | MBOLDT | | | | 1 | MBOLDT AVENU | E | | | |
| | | | | | | | SAINT P | AUL, MN 55107 | | | | |
| corrective | ort is completed be action was according to the action prefix code pm). | mplished. | Each deficiend | cy should be | fully ide | entified usir | ng either | the regulation | or LSC provis | sion number and | the | |
| ITEI | М | | DATE | ITEM | | | | DATE | ITEM | | | DATE |
| Y4 | | | Y5 | Y4 | | | | Y5 | Y4 | | | Y5 |
| ID Prefix | 20565 | | Correction | ID Prefix | 21850 | | | Correction | ID Prefix | | | Correction |
| Reg.# | MN Rule 4658.040 Subp. 3 | 05 | Completed | Reg. # | MN St. Subd. 1 | Statute 144. | 651 | Completed | Reg. # | | | Completed |
| LSC | | | 12/16/2016 | LSC | | | | 12/16/2016 | LSC | | | |
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| REVIEWE STATE AG | | REVIEWE (INITIALS | D BY) SR/KJ | DATE 01/13/2 | 2017 | SIGNATUR | RE OF SU | RVEYOR 10567 | | | DATE 12/2 | 28/2016 |
| REVIEWE CMS RO | D BY | REVIEWE (INITIALS | | DATE | | TITLE | | | | | DATE | |
| FOLLOWU | FOLLOWUP TO SURVEY COMPLETED ON | | | | | | | DEFICIENCIES CMS-2567) SEN | | | □ ye | з 🗆 по |

Page 1 of 1 EVENT ID: PUYM12

YES NO

10/5/2016

POST-CERTIFICATION REVISIT REPORT

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|------------------------------------|---------------------------------|------------------------|--|---|--|---|--|---------------------|--------------------|
| | R / SUPPLIER | | | TRUCTION | | | | DATE (| OF REVISIT |
| 245255 | ATION NUM | DEK | A. Building _{Y1} B. Wing | | | | | ,2 12/28/ | 2016 _{Y3} |
| NAME OF | FACILITY | | | | | STREET ADDRESS, CIT | | | |
| | | ENT | ER ON HUMBOLDT | | I | 512 HUMBOLDT AVENUI | | | |
| | | | | | | SAINT PAUL, MN 55107 | | | |
| program, corrected provision | to show tho | se d te su d the | leficiencies previously repo ich corrective action was ac | rted on the CMS-25 ccomplished. Each | 67, Stateme deficiency s | ent of Deficiencies and should be fully identifie | y Improvement Amendmen Plan of Correction, that have d using either the regulation on to the left of each require | ve been n or LSC | |
| ITEN | И | | DATE | ITEM | | DATE | ITEM | | DATE |
| Y4 | | | Y5 | Y4 | | Y5 | Y4 | | Y5 |
| ID Prefix | F0282 | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg.# | 483.20(k)(3) | (ii) | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | 12/16/2016 | LSC | | | LSC | | _ |
| ID Prefix | | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
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| LSC | | | | LSC | | | LSC | | _ |
| REVIEWE | D BY | | REVIEWED BY | DATE | SIGNATURE | OF SURVEYOR | | DATE | |
| STATE AG | | | (INITIALS) SR/KJ | 01/13/2017 | | | 0567 | - 1 | 28/2016 |
| REVIEWED | D BY | | REVIEWED BY (INITIALS) | DATE | TITLE | | | DATE | |
| FOLLOWU | COLLOWUP TO SURVEY COMPLETED ON | | | | RECTED DEFICIENCIES NCIES (CMS-2567) SENT | | □ VE | s 🗆 NO | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 8SV7

${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

| | PAKI | 1 - 10 BF COM | LTETED BY 1 | HE STATE | E SURVEY AGENCY | Facility ID: 00: | 538 |
|--|-------------------|---------------------------------|---|------------|------------------------------------|---|--------------|
| MEDICARE/MEDICAID PROVIDER NO. (L1) 245255 | l. | 3. NAME AND AD (L3) CERENITY | | | OLDT | 4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertit | |
| 2.STATE VENDOR OR MEDICAID NO. | | (L4) 512 HUMBO | LDT AVENUE | | | 3. Termination 4. CHOW | |
| (L2) 044518500 | | (L5) SAINT PAUI | L, MN | | (L6) 55107 | 5. Validation 6. Compla 7. On-Site Visit 9. Other | |
| 5. EFFECTIVE DATE CHANGE OF OWN | ERSHIP | 7. PROVIDER/SUI | PPLIER CATEGOR | RY | <u>02</u> (L7) | | |
| (L9) | | 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP 22 CLIA | 8. Full Survey After Complaint | |
| 6. DATE OF SURVEY 11/03/2 | 016 (L34) | 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | | |
| 8. ACCREDITATION STATUS: | (L10) | 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | FISCAL YEAR ENDING DATE: | (L35) |
| 0 Unaccredited 1 TJC 2 AOA 3 Other | | 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | 06/30 | |
| 11LTC PERIOD OF CERTIFICATION | | 10.THE FACILITY | IS CERTIFIED AS | : | | | |
| From (a): | | A. In Complian | nce With | | And/Or Approved Waivers Of The | Following Requirements: | |
| To (b): | | Program Re | | | 2. Technical Personnel | 6. Scope of Services Limit | |
| | | Compliance | Based On: | | 3. 24 Hour RN | 7. Medical Director | |
| 12 T (15 T) P 1 | 44 5 (F10) | 1. A | Acceptable POC | | 4. 7-Day RN (Rural SNF) | 8. Patient Room Size | |
| 12.Total Facility Beds | 117 (L18) | | | | 5. Life Safety Code | 9. Beds/Room | |
| 13. Total Certified Beds | 117 (L17) | | pliance with Program and/or Applied Wair | | * 0 1 | (L12) | |
| 14 LTC CERTIFIED BED DREAKDOWN | | Requirements | and/of Applied war | vers. | * Code: | (L12) | |
| 14. LTC CERTIFIED BED BREAKDOWN | | | | | 15. FACILITY MEETS | d15) | |
| 18 SNF 18/19 SNF | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | |
| 117 | | | | | | | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | |
| 16. STATE SURVEY AGENCY REMARKS | (IF APPLICABLE S | HOW LTC CANCELL | LATION DATE): | | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY AP | PROVAL Date: | |
| Susan Miller, | HFE NE II | | 11/28/2016 | (L19) | Kate JohnsTon, Pr | ogram Specialist 12/1: | 2/2016 (L20) |
| | PART II - TO | BE COMPLETE | D BY HCFA R | EGIONAL | OFFICE OR SINGLE STAT | TE AGENCY | |
| 19. DETERMINATION OF ELIGIBILITY | | 20. COM | IPLIANCE WITH (| CIVIL | 21. 1. Statement of Financ | ial Solvency (HCFA-2572) | |
| 1. Facility is Eligible to Parti | rinate | RIGI | HTS ACT: | | - | Interest Disclosure Stmt (HCFA-1513) | |
| | ripate | | | | 3. Both of the Above : | | |
| 2. Facility is not Eligible | (L21) | | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREEM | ENT 2 | 24. LTC AGREEM | ENT | 26. TERMINATION ACTION: | (L30) | |
| OF PARTICIPATION | BEGINNING | DATE | ENDING DAT | F | VOLUNTARY00 | INVOLUNTARY | |
| 09/13/1982 | BEGINNING | DITTE | LIVDING DAI | | 01-Merger, Closure | 05-Fail to Meet Health/Safe | etv |
| | | | | | 02-Dissatisfaction W/ Reimburseme | | |
| (L24) | (L41) | | (L25) | | 03-Risk of Involuntary Termination | 00-1 an to Weet Agreement | |
| 25. LTC EXTENSION DATE: | 27. ALTERNATIV | E SANCTIONS | | | 04-Other Reason for Withdrawal | OTHER | |
| | A. Suspension | of Admissions: | | | 04-Other Reason for Withdrawar | 07-Provider Status Change | ; |
| (L27) | D. Dagaind Sug | nongian Data: | (L44) | | | 00-Active | |
| | B. Rescind Sus | pension Date: | (L45) | | | | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY/C | | | 30. REMARKS | | |
| | | 02001 | | | | | |
| | <i>a.</i> • • • • | 03001 | | a | Hoolth Waiver Dague + E | 150 Emailed CMS 12/15/2016 C | 0 |
| | (L28) | | | (L31) | ricaiui waivei Kequest F2 | 158 - Emailed CMS 12/15/2016. C | U. |
| 31. RO RECEIPT OF CMS-1539 | 32 | . DETERMINATION (| OF APPROVAL DA | ATE | Posted 12/15/2016 Co. | | |
| | (L32) | | | (L33) | DETERMINATION APPRO | VAL | |



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

Fax: (651) 215-9697

Telephone: (651) 201-4118

PRINTED: 11/28/2016 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|---|---------------------|-----|---|------|----------------------------|
| | | 245255 | B. WING | | | 11/0 | 03/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER ON | N HUMBOLDT | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 12 HUMBOLDT AVENUE 6AINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | Х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | ΓS led in ePOC and therefore a | FO | 000 | | | |
| | page of the CMS-2 | uired at the bottom of the first 567 form. Electronic POC will be used as bliance. | | | | | |
| F 000 | revisit of your facilit validate that substa regulations has bee your verification. | acceptable POC an on-site y may be conducted to untial compliance with the en attained in accordance with | 5.0 | | | | 10/10/10 |
| F 280 SS=D | PARTICIPATE PLA | NNING CARE-REVISE CP | F 2 | 280 | | | 12/16/16 |
| | incompetent or othe incapacitated under | r the laws of the State, to ing care and treatment or | | | | | |
| | within 7 days after to comprehensive assinterdisciplinary teat physician, a register for the resident, and disciplines as deter and, to the extent puther resident, the resident puther resident properties. | are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, tracticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after | | | | | |
| | This REQUIREMEN | NT is not met as evidenced | | | | | |

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.

Electronically Signed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/27/2016

| - | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|--|---------------------|---|---|----------------------------|
| | | 245255 | B. WING _ | | 11/(| 03/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER O | N HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP C 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 280 | review, the facility of comprehensive car for reducing risk of (R102) reviewed for Findings include: R102 had diagnose breath, generalized heart failure, acute pressure, anemia (cells to carry oxyge) The care area asservealed R102 required ambulating, supervunsteady when amount of standing, turning toilet, and transferr The assessment in Event reports indicate month of Octob 10/17/16, 10/25/16 falls happened who bathroom alone in broken finger. Proginterventions review team. R102 broke the riguitation of the standing and fell. Instructed R102 to right hand most of | tion, interview, and document failed to update the re plan to include interventions falls for 1 of 4 residents | F 28 | The facility has policies and in place to assure the reside right, unless adjudged incorporate of the laws of the State, to par planning care and treatment care and treatment. The concare plan must be developed days after the completion of comprehensive assessment an interdisciplinary team, the attending physician, a regist with a responsibility for the other appropriate staff in distinct determined but the resident and, to the extent practicab participation of the resident resident is family or the resident in a family or the resident in the resident in the policy and procedure to the policy and procedure to the policy and procedure to the policy and appropriate. The policy and titled Fall Event and Post Family or the resident in the policy and deemed in the policy and the properties. All residents who have had past 90 days or have been at risk for falls have had the reviewed and updated if neurolude individualized interventing prevent falls. | ent has the impetent or obacitated under reticipate in at or changes in omprehensive ed within 7 if the at; prepared by at includes the tered nurse resident, and sciplines as at a needs, le, the sident is legal cally reviewed utilified ment. Itled Care Plan deemed diprocedure all Assessment appropriate. In updated with ons used to be air care plans cessary to | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | TIPLE CONSTRUCTION | | E SURVEY IPLETED |
|--------------------------|--|---|--------------------|--|--|----------------------------|
| | | 245255 | B. WING | | 11/ | 03/2016 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 280 | bathroom in room notes dated 10/14 provided a spill prof getting up to go discussed proper bathroom, and su non-skid socks. On 10/17/16 at ap slipped off wheeld 10/18/16 indicated had been complet nursing program f pivot, limited assist On 10/25/16 at ap found R102 lying lounge. R102 exp trying to weigh sel 10/25/16, staff not next to R102's root station. According previous falls relaip present. Staff remalone, and decide opposite lounge swalk past the nurs Staff also disconting and started weekl On 10/27/16 at ap was turning to use Progress notes for resident was able urinal from bed, be documented re-editored. | :30 p.m., R102 was using the just before falling. Progress /16 indicated R102 was pof urinal to use at night instead to the bathroom. Staff also footwear when walking to the oplied R102 with a new pair of proximately 5:00 a.m., R102 hair. Progress notes dated a physical therapy evaluation ed, and the rehabilitation or transfers included stand of one, and use of a gait belt. proximately 6:45 a.m., staff on right side, on the scale in the lained that before falling, was f. In progress notes dated ed the scale was in the lounge of the notes, R102 had seed to weighing self without staff inded R102 not to use the scale do to move the scale to the other esident would have to ses' station to get to the scale. Indeed an order for daily weights, | F 2 | Mandatory education for a nursing staff will be provid December 6th and Decem Education will include revititled Care Plan Revision and Post Fall Assessmen expectations for updating fall interventions. Care plan audits will be concerned as a concerned to the care plan audity concerned to the Quality Concerned to the Qua | ded on on the roth, 2016. Hew of policies and Fall Event the tas well as the care plans with completed after replan was not the plan was not t | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | | E SURVEY MPLETED |
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| | PROVIDER OR SUPPLIER | N HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 280 | access up to date in care of each reside information about sand bed time, dieta repositioning, activitransfers, rehabilitatiems (bath, weight interventions. R102 directed staff to ke a splint at all times supervise toileting, bedside and encouremind resident to one for transfer, us belt, and to use noon. The falls care plan mentioned R102 wunsteadiness wher standing, moving of transferring from splan did not mentioned R102 wunsteadiness wher standing, moving of transferring from splan did not mentioned R102 wunstead injuries through the dated 8/21/16, was related injuries through the call light if therapy consult, or changes in furnitur | used Care Cards to quickly information about how to take ent. Care cards included special needs, wake-up time ary information, toileting and ities of daily living, ambulation, ation programs, scheduled its, etc.), and special 2's care card, dated 11/03/16, ep the resident's right hand in (remove for hygiene), keep a spill proof urinal at the grage the resident to use it, use call light, limited assist of se of pivot transfers and gait in-skid socks when possible. Was last edited 8/21/16, and was at risk for falls due to an moving from sitting to an and off the toilet, and surface to surface. The care on that R102 fell five times in a finger. The long term goal, as to keep R102 free from fall bugh 11/30/16. The facility last eaches used to meet this goal baches listed: analyze R102's patterns, avoid restraint use, in reach, obtain a physical itent R102 when there are eplacement or environment, ent clutter free, and use a | F 280 | , | | |
| | plan was last edite | times. ily living/rehabilitation care d 11/02/16, and highlighted nobility. This care plan included | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION IG | | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER TY CARE CENTER ON | I HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
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| F 280 | (stand pivot, limited but did not include the required supervision.) Although nursing as current intervention the facility did not uncare plan after recent treatment and interestaff and reviewed because a spill profession of the facility policy to getting up to go to the socks when approped. The facility policy tithe Assessment, last upolicy of building, of the total commented in all Card, Care Plan, etc. In an interview on 1 asked about whether interventions for receptant, Registered Nuand history of fracture care plan. I will nee put all that in the care card so that the stars. | ation program for transfers assist of one, use gait belt), the assessment that R102 in with toileting. Sistant care cards provided is used to reduce risk of falls, pdate R102's comprehensive int falls to include the following ventions determined by clinical by the interdisciplinary team: ured right hand most of the of urinal at night to avoid the bathroom, wear non-skid driate, and supervise toileting. Iled, Fall Event and Post Fall podated 12/15, instructed the clinical manager, or designee implemented intervention(s) I necessary places (Care | F 28 | | | |
| F 282 SS=E | PERSONS/PER CA The services provide must be provided b | RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of | F 28 | 32 | | 12/16/16 |
| | | • | | | ļ | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | LE CONSTRUCTION | (X3) DATE COMF | SURVEY |
|--------------------------|---|--|---------------------|--|---|----------------------------|
| | | 245255 | B. WING | | 11/0 | 3/2016 |
| | PROVIDER OR SUPPLIER | N HUMBOLDT | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE S12 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | , | <u> </u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 282 | This REQUIREME by: Based on observa review, the facility of plan for 1 of 3 residental needs; for 1 required staff assist of 5 residents (R31 assistance with inceeds). | NT is not met as evidenced tion, interview and document failed to implement the care dents (R75) with identified of 3 residents (R63) who stance with oral care, and for 2, R24) who required ontinent care. | F 282 | , | vided vritten viewed cy ewed y titled | |
| | having broken and R75 was to see the On 11/02/16, at 1:3 (HUC)-G reviewed had been to the de dentist had recommonths later. No refound in the record time by HUC-G. R63, document revellan, dated, 3/20/10 oral cares. The document acres. The document is NPO (TF (tube feeding) Scares-mouth swabs | sed 8/29/16, identified R75 as missing teeth and indicated e dentist as needed. 89 p.m. health unit coordinator R75's record and found R75 ntist on 3/31/15, and the mended a return visit six eturn visit to the dentist was and this was confirmed at this view of the form titled, Care 15, read, total assistance with cument titled, Care Area o dated 3/10/16, read, nothing per oral) and receives Staff assist with oral s Q2H (every 2 hours). Thick g over tongue, had been | | and deemed appropriate. R75 was discharged from the facilit 11/20/16. Multiple attempts to reac Responsible Party by phone were n by facility staff. A copy of the conserwas at the Nursing Station for the Responsible Party to sign, if he visit certified letter, including a copy of the Consent Form, was mailed to the Responsible Party and was not returned to the Responsible Party and seed or all needs. He is offered/provided oral of with repositioning. The care plan has 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 Care Card. | y on h the nade nt form ted. A ne urned care care as been | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION | | E SURVEY PLETED |
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| | | 245255 | B. WING | | 11/0 | 03/2016 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO | I SHOULD BE | (X5) COMPLETION DATE |
| F 282 | treated with nystat appear to be thrus discomfort, no ble and coating is only cheeks. Per wife is started TF. Staff to cares and will refe Document review directed nursing sithours. During observation was observed to have the lips and tongue heavy coating on that it was bothers present and stated provide oral care expre-moistened swid drawers currently a having to ask for not think the oral of two hours. During continuous 11/2/16, from 7:30 was observed to be no offers to provide or 11/2/16, at 1:2 nursing assistants room with R63 provided to R63 yes the oral care now. Document review dated revised Octo | in but no effect-does not h. Resident denies any eding, or open areas present, on tongue-not sides of las been present since he continue to assist with oral redoction to dental prn." of the form titled, Care Sheet, laff for mouth swabs every two in on 11/1/16, at 3:00 p.m. R63 ave a white moist substance on e. R63 was observed with a he tongue and did complain ome. Family member (F)-B is at the facility is suppose to every two hours using the labs but there are none in the land F-B verified frequently more swabs because F-B did lares were being provided every observations of R63's care on a.m. through 12:15 p.m.: R63 e lying in bed and there were e oral care. 1 p.m. registered nurse (RN)-A, (NA)-A and NA-B were in the eviding care, and when ead no oral care had been est today but they would provide | F 2 | All residents with tube feeding reviewed, swabs are at the cards and care plans were appropriate. All care plans for residents assistance with oral care careviewed and updated as not all and R24 have had a new Bladder Assessment complimisture. Tolerance Test and Ended have also been completed. plans have been reviewed an eeded. NA/R is will be trained to reconcoming NA/R to provide plans have been reviewed an eeded. NA/R is will be trained to reconcoming NA/R to provide plans for residents assistance with incontinent been reviewed and updated. Mandatory education for all will be provided on December 7th, 2016. Educinclude review of policies tit Care, Urinary Incontinence Following the Plan of Care, expectations for following the providing oral care, inconting and ensuring dental appoint and attended as recomment. Audits for oral care and inconsistance will be complete alternating on all three shifts. | bedside, care updated where who require ares have been eeded. We Bowel and eted. New Braden Scales The care and updated as bund with the pertinent ents they will ift. Who require care have d as needed. Inursing staff per 6th and eation will led Mouth as well as the ne plan of care, ence care, its are made ided. | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| | | 245255 | B. WING _ | ···· | 11/0 | 03/2016 |
| | PROVIDER OR SUPPLIER | N HUMBOLDT | | STREET ADDRESS, CITY, STATE, 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 282 | p.m. verified the far provide oral care e R31's urinary incorrupdated 10/10/16, bladder and bowel, the care plan was flevel of bladder and this goal, the care plan this goal, the care plan toileting every two one. R31's nursing assist 11/03/16, directed every two hours with the celling continuous 8:22 a.m. until 11:2 leaving bedroom us reclining chair in frowas observed mov sitting in the reclining chair in the dining room, the reclining chair in the dining room, the reclining walker and walked down the rolling walker dark marking on it. brief and dress and wet my pants, I we the laundry?" At this down to R31's bed nurse helped R31 | with RN-A on 11/2/16, at 1:30 cility expectation was to very two hours. Intinence care plan, last indicated R31 was continent of The long term goal listed in for R31 to maintain current d bowel continence. To meet plan directed staff to provide hours with extensive assist of stant care card, dated care staff to provide toileting the extensive assist of one. Observation on 11/03/16 from P4 a.m., R31 was first seen sing rolling walker to reach a cont of the nurses' station. R31 ing back and forth between ng chair, and sitting at a table R31 remained sitting either in for the dining room for three n. R31 got up from the table he hall toward bedroom using The back of R31's dress had a R31 got to bedroom, took off it seemed distraught saying, "I to the part of the nurse had come to give medications. The pout on a clean brief and dress, cations. When asked whether | F 2 | and then 3 x/week alter AM and PM shifts throu 2017. Audits of dental a be completed after each appointment to ensure a made as recommended the calendar. All audits will be reported Council in January and shall determine if ongoing is required. The Directon Nursing/designee shall monitoring compliance. Date of completion: Decompletion: Decompletion | gh January 24, appointments will on dental appointments are all and written on the decided to the Quality the Quality Counciling audit schedule or of the responsible for | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | TE SURVEY MPLETED |
|--------------------------|---|---|---------------------|--|---------|----------------------------|
| | | 245255 | B. WING _ | | 11 | /03/2016 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 282 | nurse (RN-E) said encouraged toileting one with activities. On 11/03/16 at 12: administrator (TM/A) bathroom independent while. TMA-A said ask R31 every two but the resident mile. In an interview on registered nurse (Fiso she does toilet should be prompting RN-B confirmed Fix with the briefs, and probably needed to | 03/16 at 11:02 a.m. registered R31 was independent but staffing, and that R31 was assist of | F 28 | 2 | | |
| | 8/8/16, directed statollet due to inabilit that R24 required, hours. Total dependent | re plan dated as edited on aff that R24 does not use the y to sit on the toilet safely and "Check and change q [every] 2 dence of 1-2 staff to check, de good peri care after each es." | | | | |
| | 8/8/16, identified F is at risk for skin in AEB incontinence, for ADL's [assist of APPROACH: Chec | care plan dated as edited on 24 had "PROBLEM: Resident apairments and pressure ulcers immobility, totally dependent daily livings], and mobility, ck and change Q 2 hours and care after incontinence. Report | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | FIPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| | | 245255 | B. WING | | 11/(| 03/2016 |
| | PROVIDER OR SUPPLIER Y CARE CENTER ON | I HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORRECTIOI ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 282 | repositioning obsernhours of positioning Reposition Q 2 hours of positioning Reposition Q 2 hours of position | down to nurse. Per turning and vation resident tolerates 2 without redness noted. It is as resident allows." It is is as resident allows." It is is istant assignment sheet esent for cares Toileting: TA2 Change every 2 hours and per ing: TA2 every 2 hours Heels in bed". In p.m., during observations of notinent of bowel and bladder note pad was checked and fied R24 was incontinent with the standard every | F 2 | 82 | | |
| F 312 | _ | ARE PROVIDED FOR | F 3 | 12 | | 12/16/16 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION (| X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|--|--|
| | | 245255 | B. WING | | 11/03/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER OF | N HUMBOLDT | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 12 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | |
| F 312 SS=D | DEPENDENT RES A resident who is u daily living receives maintain good nutr and oral hygiene. This REQUIREME | _ | F 312 | | |
| | review, the facility f of 1 resident's (R63 personal cares; and | tion, interview and document failed to provide oral care for 1 B) dependent upon staff for d failed to check and change 1 dependent on staff for | | The facility has policies and procedin place to ensure residents who are unable to carry out activities of daily received the necessary services to maintain good nutrition, grooming arpersonal and oral hygiene. | living |
| | white moist substate R63 was observed tongue and did confamily member (F) facility is supposed hours using the preare none in the drafrequently having to questioned if oral devery two hours. During continuous 11/2/16, from 7:30 | 11/1/16, at 3:00 p.m. to have a nce on the lips and tongue. with a heavy coating on the nplain that it was bothersome. It was present and stated the to provide oral care every two emoistened swabs but there wers currently and F-B verified to ask for more swabs. F-B ares were being provided observations of R63's care on a.m. through 12:15 p.m., R63 are lying in bed and there were every coal care. | | The policy titled Mouth Care was revand deemed appropriate. The policy Following the Plan of Care has been reviewed and deemed appropriate. policy titled Urinary Continence and Incontinence Assessment and Management was reviewed and dee appropriate. R63 has been re-assessed for oral canneds. He is offered/provided oral canneds. He is offered/provided oral canneds. He is offered/provided oral canneds are viewed 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/Care Card. | y titled The Emed care are s been |
| | | p.m. registered nurse (RN)-A, (NA)-A and NA-B were in the | | All residents with tube feedings were reviewed, swabs are at the bedside. | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION | | SURVEY PLETED |
|--------------------------|--|--|--------------------|--|---|----------------------------|
| | | 245255 | B. WING | | 11/0 | 3/2016 |
| NAME OF I | PROVIDER OR SUPPLIEF | l . | | STREET ADDRESS, CITY, STATE, ZIP C | • | |
| CEDENIA | TY CARE CENTER O | N HUMBOLDT | | 512 HUMBOLDT AVENUE | | |
| CEREINI | IT CARE CENTER C | NIOMBOLDI | | SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 312 | room with R63 prointerviewed, verific provided to R63 yethe oral care now. R63's quarterly Mi 3/9/16, indicated F was dependent wi (ADL's). Document review dated, 3/20/15, reacares. The docum Assessment (CAA "Resident is NPO TF (tube feeding) cares-mouth swall white/yellow coating treated with nystat appear to be thrus discomfort, no bleand coating is only cheeks. Per wife h started TF. Staff to cares and will refe Document review directed nursing shours. Document review dated revised Octothe resident's care needs of the resident During an interview of the resident | prividing care, and when and no oral care had been be not today but they would provide an immum Data Set (MDS) dated a feat and intact cognition and the activities of daily living and total assistance with oral ent titled, Care Plan, and, total assistance with oral ent titled, Care Area and dated. 3/10/16, read, (nothing per oral) and receives Staff assist with oral as Q2H (every 2 hours). Thick are over tongue, had been in but no effect-does not an in but no effect-does not an individual entitled. Resident denies any ending, or open areas present, or on tongue-not sides of an as been present since he of continue to assist with oral or to dental prn." To the form titled, Care Sheet, that for mouth swabs every two entitled assess for any special ent. We with RN-A on 11/2/16, at 1:30 actility expectation was to | F3 | cards and care plans were appropriate. All care plans for residents assistance with oral care careviewed and updated as not be a bowlet and Bladder Assessment completed. R24 has had a new Bowel at Assessment completed. A Tolerance Test and Braden also been completed. The have been reviewed and upneeded. NA/R s will be trained to reconcoming NA/R to provide information about the reside be caring for on the next shall care plans for residents assistance with incontinent been reviewed and updated. Mandatory education for all will be provided on December 7th, 2016. Educinclude review of policies tit Care, Following the Plan of Urinary Continence and Inconservations for following care, providing oral care, in care and ensuring dental apmade and attended as reconcept. | who require ares have been eeded. A new ment has been and Bladder new Tissue Scale have care plans odated as bund with the pertinent ents they will ift. who require care have d as needed. nursing staff per 6th and eation will led Mouth of Care, and ontinence lent as well as no tontinence lent as well as no tontinence points are ommended. | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | LE CONSTRUCTION | | SURVEY PLETED |
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| | | 245255 | B. WING | | | 11/0 | 3/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER O | N HUMBOLDT | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE S12 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 312 | Resident (R24) wa bladder, and did no incontinence care on 11/2/16 from 7:5 hours and 47 minu. On 11/1/16 at 3:44 be incontinent with check and change verified R24 was in bladder. On 11/2/16, during 7:57 a.m., until 10: for incontinence. T - Between 7:57 a.m. observed to be in t closed. The bed was covered with bed s and had a pillow or - At 8:31 a.m. nurs R24's room, looked room without proving R24 From 8:32 a.m. u back in bed with ey position. R24 cove blue blanket and had a pillow or at 8:32 a.m. u back in bed with ey position. R24 cove blue blanket and had a pillow or speaking to - Between 9:12 a.m. observed lying on the bed was in low with bed spread sha pillow on abdome - From 9:12 a.m. u | s incontinent of bowel and of receive assistance with every two hours on 11/1/16 and 57 a.m., until 10:44 a.m., (two tes) p.m., R24's was observed to bowel and bladder during of the incontinent pad. NA-Z acontinent with bowel and continous observations. from 44 a.m., R24 was not checked he following was observed: n. and 8:31 a.m. R24 was he bed, lying on back with eyes as in low position and R24 was pread sheet and blue blanket in abdomen area. In assistant (NA)-A entered did at R24 and stepped out of the ding cares and/or speaking to not es closed. The bed was in low red with bed spread sheet and ad a pillow on abdomen area. A entered R24's room, looked the closet, closed it, and room without providing cares R24. n. and 9:42 a.m. R24 was covered seet and blue blanket and had reserved and blue blanket and had | F3 | 312 | alternating on all three shifts x 2 we and then 3 x/week alternating betw AM and PM shifts through January 2017. Audits of dental appointmen be completed after each dental appointment to ensure appointmen made as recommended and writter the calendar. All audits will be reported to the Qu Council in January and the Quality shall determine if ongoing audit scr is required. The Director of Nursing/designee shall be responsimonitoring compliance. Date of completion: December 16, | een 24, ts will ts are n on ality Council nedule ible for | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | E SURVEY PLETED |
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| | | 245255 | B. WING | | | 11/(| 03/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER ON | N HUMBOLDT | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 12 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 312 | - At 9:43 a.m. NA-A looked at the room - Between 9:43 a.m observed to be in b closed. The bed was covered with a bed and had a pillow on - At 9:49 a.m. NA-A at R24 and stepped providing cares, surepositioning and/o - From 9:49 a.m. to observed in bed, ly and bed in low posibed spread sheet a pillow on abdomen - At 10:41 a.m. NA-mechanical Hoyer I morning cares which change of R24's incremoval of the wet thighs had numeror crevices from the wwere blanchable at NA-A confirmed R2 checked and change added, is a heavy where the confirmed R2 checked and bowel, two staff for bed more care Area Assessing dated 5/12/16, reacon lincontinence D/T [classistance with toil incontinent of bladding and bowel, two staff for bed more continents of bladding and bowel, two staff for bed more care and season and the continence D/T [classistance with toil incontinent of bladding and bl | A. walked past R24's room, but never entered. I. and 9:49 a.m. R24 was ed, lying on back with eyes as in low position. R24 was spread sheet and blue blanket abdomen area. I entered R24's room, looked dout of the room without ch as check, change, r speaking to R24. I 0:41 a.m. R24 was ring on back with eyes closed ition. R24 was covered with and blue blanket and had a area. A entered R24's room with ift. NA-A started to perform the included, turn, check and continence brief. Upon brief, R24's buttocks and as reddened areas and rinkling of the brief. The areas the time and skin was intact. A was last repositioned and ged around 7:30 a.m. and | F | 312 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | ELE CONSTRUCTION | | E SURVEY PLETED |
|--------|---|---|---------------------|--|------|----------------------------|
| | | 245255 | B. WING | ····· | 11/0 | 03/2016 |
| | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | D BE | (X5) COMPLETION DATE |
| F 312 | PRN [as needed]". R24's self-care car 8/8/16, identified R toileting, does not con toilet safely and every 2 hours. The required total depechange, and providincontinent episode R24's skin integrity 8/8/16, identified, "remain intact throu APPROACH: Chec PRN, provide. Peri Report redness and Undated nursing as reads, " 2 staff pr [total assist of two] request." On 11/2/16, at 11:0 (RN)-A indicated the tofollow the care phave been checked incontinence. Policy and procedu CONTINENCE ANI ASSESSMENT ANI September 2010, odocument the resu resident's medical change' strategy in continence status a incontinence device. | e plan dated as edited on 24 had a self care deficit in use toilet due to inability to sit requires check and change plan directed staff that R24 ndence of 1-2 staff to check, le good peri care after each e. care plan dated as edited on GOAL: Resident's skin will gh the next review date. Ex and change Q 2 hours and care after incontinence. It is breakdown to nurse." ssistant assignment sheet resent for cares Toileting: TA2 Change every 2 hours and per 9 a.m. the registered nurse re expectation was for all staff lan and verified R24 should devery two hours for | F 312 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | |
|--|---|--|---------------------|---|----------------------------|--|--|
| | | 245255 | B. WING | | 11/03/2016 | | |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | | |
| F 312 F 314 SS=D | protect the skin." 483.25(c) TREATMENT/SVCS TO | | F 312 F 314 | | 12/16/16 | | |
| | resident, the facility who enters the facil does not develop p individual's clinical they were unavoida pressure sores received. | rehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing. | | | | | |
| | by: Based on documer interview, the facilit residents (R63, R24 pressure ulcers (PU repositioning. Findings include: R63 who was at risulcers did not receivours. Document review of (CAA) dated 3/9/16 cognitively intact and R63 was assessed for pressure ulcers, load independently, repositioning every daily with cares and | nt review, observation and y failed to ensure 2 of 3 4) identified at risk for J) received timely k of developing pressure we a position change for 4 f the Care Area Assessment indicated R63 was ad able to make needs known as being moderately at risk and directed, unable to off assist with turning and two hours, staff monitor skin d licensed staff assess every y audit. The plan of care dated | | The facility has policies and procedur 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 sore unless the individual sclinical condition demonstrates that they were unavoided 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. | dent, t e s on | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|---|--|----------------------------|--|
| | | 245255 | B. WING | | 11/0 | 3/2016 | |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | ţ | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | 11700/2010 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE | D BE | (X5) COMPLETION DATE | |
| 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. NA-A and NA-B positioned R63 to the 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. | | F 314 | DEFICIENCY) | sed for risk for should raden sted adings and care dated ith the ent ey will sed as ace with sed and equire ave eeded. | | |
| | when interviewed registered nurse (open area to the rRN-A was not awa have last changed | | | resident was repositioned before to their shift, and pass the docume to the oncoming shift. Mandatory education for all nursin will be provided on December 6th December 7th, 2016. Education vinclude review of policies titled Fo the Plan of Care, and Repositioning | the end entation ag staff and will llowing | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245255 | B. WING | | | 11/0 | 3/2016 |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | | (X5) COMPLETION DATE |
| F 314 | system to commun time changes for reassessed at risk for R63 was administe 11/2/16, at 11:04 a. assessed the right ulcer, and measure (centimeter) width (Contimeter) width (Contimeter) width (Conditions for R63. completed weekly bath Day B 10/9/16, indicated reconditions for R63. completed weekly be November to review When interviewed overified speaking weekly bath audit with 10/9/16, but would verified R63 did not hours and the faciliar require an every two verified the pressureffective due to the sheet being used of mattress. R24 was at risk for repositioned every 7:57 a.m., until 10:4 minutes). | icate change of shift position sidents who have been skin breakdown. red pain medication on m. and at 11:50 a.m. RN-A hip as a stage 2 pressure ments length 1.5 cm 0.5 cm and depth 0.2 cm. If the facility form titled, ody Audit Form, dated, no open areas or skin There were no other body audits for October or | F3 | 314 | well as the expectations for following plan of care, and proper use of preceducing equipment. Audits for repositioning will be common 5 x per week on all shifts for 2 weethen 3 x per week on varied shifts to January 24, 2017. All audits will be reported to the Quality shall determine if ongoing audit sort is required. The Director of Nursing/designee shall be responsimentaring compliance. Date of completion: December 16, | pleted ks and through eality Council nedule ible for | |

| . , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245255 | B. WING _ | | 11/ | /03/2016 | | |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | | |
| F 314 | (4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | F 31 | 4 | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING | | 11/ | 03/2016 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 314 | and had a pillow of At 10:41 a.m. NA mechanical Hoyer morning cares incl of R24's incontiner wet brief, R24's but numerous reddens wrinkling of the brief the time and the At 10:59 a.m. a Norepositioned aroungets dressed and it is incontinence of B/I [Peripheral vascula [history] of pressured assistance with all [every two hours] at cares, skin assess body audit" The quarterly Minimal (and R24 was at risulcers). R24's skin integrity 8/8/16, identified Fand pressure ulced dependent on staff goal was for R24's skin goal was fo | spread sheet and blue blanket in abdomen area. -A entered R24's room with lift. NA-A started to perform uding turn, check and change nee brief. Upon removal of the ittocks and thighs had areas and crevices from the ef. The areas were blanchable | F 314 | 4 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING | | 11/ | 03/2016 |
| | PROVIDER OR SUPPLIER FY CARE CENTER OF | N HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | D BE | (X5) COMPLETION DATE |
| F 314 | after incontinence. breakdown to nurs repositioning obser hours of positioning Reposition Q 2 hours of positioning as reads, "Repositioning as reads, "Repositioning up on pillows when On 11/2/16, at 11:0 (RN)-A explained the nursing staff to folke R24 should have be hours. Policy and procedurevised May 2013, Repositioning is crimmobile or dependence of the propositioning. Intering bed should be on (q2h) repositioning 483.25(d) NO CAT RESTORE BLADD Based on the resident who enterindwelling catheter resident's clinical of catheterization was who is incontinent of treatment and service. | and PRN, provide. Peri care Report redness and e. Per turning and rvation resident tolerates 2 g without redness noted. urs as resident allows." ssistant assignment sheet ing: TA2 every 2 hours Heels in bed". 9 a.m. the registered nurse that the expectation is for all ow the care plan and verified een repositioned every two ure title REPOSITIONING, directed staff, "3. titical for a resident who is dent upon staff for ventions 3. Residents who are n at least an every two hour schedule." HETER, PREVENT UTI, DER ent's comprehensive acility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that s necessary; and a resident of bladder receives appropriate rices to prevent urinary tract estore as much normal bladder | F3 | | | 12/16/16 |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' |) MULTIPLE CONSTRUCTION BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING _ | | 11/ | 11/03/2016 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | | 30,2010 | |
| CERENI | TY CARE CENTER O | N HUMBOLDT | | 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 315 | Continued From pa | age 21 | F 3 | 15 | | | |
| | by: Based on observareview, the facility (R63, R31) in the sincontinent of urine and services to material final services (CAA) dated 3/9/16 cognitively intact a R63 was assessed staff due to cerebrate the services of the services | of the Care Area Assessment 5, indicated R63 was and able to make needs known. If as being total assist of 1-2 all vascular accident and right as incontinent of bladder and is assessed as moisture mage (MASD) to peri area, um/coccyx with scabbing ous experiences with er cream with each de was to be applied and staff change for incontinence every atted 9/6/16, directed, self care ue to total assistance with use toilet or commode due to continent of bowel and bladder stance of two staff for | | The facility has policies are in place based on the reside comprehensive assessme ensures that a resident where facility without and indwelling not catheterized unless the clinical condition demonstrate catheterization was necessore resident who is incontinent receives appropriate treatment services to prevent urinary and to restore as much not function as possible. The policy titled Managem Incontinence was reviewed appropriate. Resident R63 and R31 has reassessed for incontinence Bowel and Bladder Assessibeen completed. The care been reviewed and updates. Residents who required as manage their incontinence reviewed and reassessed Assistance with incontinent as assessed and care plan. Mandatory education for a will be provided on December 7th, 2016. Eduinclude review of policies to Management of Incontinent the expectations for provided. | dent s int, the facility in enters the ing catheter is e residents rates that sary; and a t of bladder ment and ract infections rmal bladder ent of d and deemed ve been ce needs. New sments have e plans have ed as needed. ssistance to e have been as needed. ice is provided ined. Il nursing staff aber 6th and ication will itled ince, as well as | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING | | 11/0 | 03/2016 |
| | PROVIDER OR SUPPLIER | N HUMBOLDT | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 12 HUMBOLDT AVENUE 6AINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 315 | incontinence of uring When interviewed nursing assistant (I time the night shift check and change NA-B verified R63 incontinence earlied On 11/2/16, at 10:00 to assist NA-B with urine and loose both and hips had deep there was redness, perineal areas from bowel. When interviewed registered nurse (Fithe night shift would changed R63 for in Currently the facility communicate chart times for incontinent when interviewed verified speaking with R63 had a check at 6 a.m. and NA-A venot occur until after time span without a incontinence. RN-A expectation would every two hours for R31 admitted to the | on 11/2/16, at 10:00 a.m. NA)-B was not aware of what would have completed a for R63's incontinence and had not been checked for r in the shift. O a.m. NA-A came to the room a cares. R63 was incontinent of wel movement. R63's buttocks red creases and crevices and dirritation to the groin and an incontinence of urine and continence but would find out. By did not have a system to age of shift check and change not. On 11/3/16, at 9:30 a.m. RN-A with the night shift who affirmed and change for incontinence at perified a check and change for a check and change R63 | F 315 | care to residents as directed by plan. Audits for repositioning will be compared to the special shifts for 2 with the street of the special shifts and the special shall detended and the | ompleted eeks and ts through be I January ermine if ed. e shall be liance. | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | 245255 B. WING | | | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 315 | always continent of The urinary care a 7/14/16, revealed toileting, and was a The care area ass 7/14/16, revealed needed assistance. Quarterly minimum revealed R31 was bladder (less than incontinence durin. In a progress note that R31 had been during the look bar resident needed a every two hours duand fixation on toil R31 needed extentoileting and perind briefs. The urinary incontinuo/10/16, indicated and bowel. The lor plan was for R31 the bladder and bowel the care plan direct every two hours we R31's nursing assinursing assinursing continuous 8:22 a.m. until 11:2 | rea assessment, dated R31 required limited assist with continent of bladder and bowel. essment worksheet, dated R31 had urinary urgency and | F 3 | 15 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING | | 11 | /03/2016 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 315 | was observed move sitting in the reclining in the reclining room. The reclining chair hours. At 11:24 a.m. and walked down to the rolling walker. It dark marking on it brief and dress and wet my pants, I we the laundry?" At the down to R31's bed nurse helped R31 and gave the medistaff helped with to "Sometimes." On 11/03/16 at 12: administrator (TMA bathroom independ while. TMA-A said ask R31 every two but the resident million in an interview on registered nurse (F so she does toilet I should be prompting RN-B confirmed F with the briefs, and probably needed to toileting, as the toil written. In an interview on | ont of the nurses' station. R31 ring back and forth between ng chair, and sitting at a table R31 remained sitting either in or the dining room for three n. R31 got up from the table the hall toward bedroom using The back of R31's dress had a R31 got to bedroom, took off d seemed distraught saying, "I t my pants. Can you put this in it is time the nurse had come room to give medications. The put on a clean brief and dress, cations. When asked whether sileting, R31 replied 14 p.m., trained medication A-A) said that R31 goes to the dently, but wets brief once in a that staff were supposed to hours to go to the bathroom, ght not want to go. 11/03/16 at 11:40 a.m., RN-B) said R31 was continent herself at times too, but staffing R31 to go to the bathroom. R31 needed extensive assist I said the nursing aid care card to be reworded in regards to eting program was not clear as | F 31 | 5 | | | |
| | that R31 was conti | coordinator (MDS-F) confirmed nent on the admission During the guarterly | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING _ | | 11/0 | 03/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER OF | N HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 325 SS=D | the look back period occasionally incontrated might expect to because of the occasid it was hard to that anyone would just because of one When asked for a cobladder continence look back for the portion of the look back inclustant documented word to see R3 episodes of incontinuous surprised to see R3 episodes of incontinuous undersonation of the look back inclustant documented word incontinuous surprised to see R3 episodes of incontinuous undersonation of the look back inclustant documented word incontinuous surprised to see R3 episodes of incontinuous undersonation of the look back inclusion of the look back | nad one incontinent episode in d, so staff coded R31 as inent. When asked whether the care plan to change asional incontinence, MDS-F say, but generally didn't think have re-written the care plan e episode of incontinence. documented history of R31's of MDS-F printed a seven day eriod of 10/28/16-11/03/16. Inded 17 total entries where whether R31 had been nent of bladder. MDS-F was say had 12 documented nence out of 17 total entries. N NUTRITION STATUS DABLE of the cility must ensure that a stable parameters of nutritional day weight and protein levels, the cilical condition this is not possible; and respectic diet when there is a | F 3: | | | 12/16/16 |
| | by: Based on observareview, the facility for weight loss for | NT is not met as evidenced tion, interview and record ailed to minimize the potential of 3 residents (R130) ight loss of greater than 10% | | The facility has policies and proced in place to ensure based on a resident comprehensive assessment, that the resident (1) Maintains acceptable | lents ne | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | LE CONSTRUCTION | COMPLETED | |
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| | | 245255 | 245255 B. WING | | | |
| | PROVIDER OR SUPPLIER TY CARE CENTER O | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 325 | in a sixty day period Findings include: On 11/2/16, at 11:2 being served three cereal and two slice wellness directors was all the resident R130 was observed bowl of cereal, two bites of toast before R130 was not offer and was observed At 10:44 a.m. R13 R130 was asked a replied, did not was a replied, did not was a review of record period dated 8/26-gone from 158 pour a 10% weight loss were physician or nutritional supplem necessary, the fact R130. A nutrition assessing R130 as having a last 60 days prior to 8/19/16. The asses high nutrition risk freceive a Mighty S A registered dietici indicated the RD weight loss over the | 29 a.m. R130 was observed e glasses of milk, a bowl of ses of toast. At 11:30 a.m. the stated the meal served R130 at wanted to eat. At 11:42 a.m. ed to have consumed 1/2 a glasses of milk and a few re leaving the dining room. red any nutritional supplement to decline further food. | F 325 | parameters of nutritional status, so body weight and protein levels, un resident is clinical condition demothat this is not possible and (2) Rea therapeutic diet when there is a nutritional problem. Resident R130 discharged on Nov 15, 2016. The nutritional supplementer order was clarified and parameters defined prior to discharge. All residents with orders for nutritic supplements have been reviewed clearly defined directions and clarithave been obtained for those that unclear parameters. The Dietician reviews resident weight a regular basis and alerts staff to residents with weight loss and recommends appropriate intervent. Mandatory education will be provided all licensed nursing staff on Decentist, 6th, and 7th, 2016, regarding nutritional supplements, obtaining clarifications if the instructions didinclude clear directions and parameters will occur weekly, and audit documentation of being offered nursupplements will occur daily on vashifts through January 24, 2017. A audits will be reported to the Quality shall determine if an ongoing audit schedule is required. The Director Nursing/designee shall be response | less the instrates ceives ember ent is onal instrations for fications had ghts on the eters. In the eters of tritional ried in the eters of tritional ried in the eters of tritional ried is of tritional ried in the eters of tritional ried is of the eters of tritional ried is of the eters of tritional ried is referred to the eters of the eters | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING _ | | 11/ | 03/2016 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | • | 00/2010 | |
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| F 325 | made her sick; and change in nutrition versus Mighty Sha A RD note dated 9 a 10 pound weight Ensure was being 3 of 17 refusals; ar complaining of nau. A RD note 9/16/16 daily probiotic yogustools and weight I A RD note dated 9 returned from the hyneumonia and that was much better a On 10/7/16, the physician ordered administered three However, the physician ordered administered and tolarification on para A RD note dated 1 weight loss and the day, when necessar RD note also ident received the nutritithe physician had on 11/2/16, at 12:0 (TMA)-D was asket | If the resident requested a all supplement to Ensure ke. /13/16, revealed the following: loss in less than a month; offered three times a day, with and the resident was usea and not feeling well. , revealed R130 was taking a urt daily, had frequent loose oss noted at 11.4 pounds. /29/16, indicated R130 recently hospital after a bout with at R130 had told the RD eating and loose stools had improved. ysician ordered a nutritional Boost Glucose Control. The the supplement to be times a day, when necessary, ician did not identify any en the supplement was to be he facility did not get ameters of use. 0/25/16, noted the resident's enthe order for three times a dary, nutritional supplement. The ified that R130 had not onal supplement since the date | F 32 | monitoring compliance. Date of completion: Decem | ber 16, 2016 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING | | 11/03/2016 | |
| | PROVIDER OR SUPPLIER TY CARE CENTER ON | I HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
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| F 332 SS=E | had not offered the On 11/2/16, at 12:0 responsible for orde for the facility and h Glucose Control su On 11/2/16, at 12:1 completed the 10/2 explained being at t verified there were know when to admi nutritional suppleme verified R130 had n that was ordered by 483.25(m)(1) FREE RATES OF 5% OR The facility must en medication error rat This REQUIREMEN by: Based on observat review, the facility fa were administered residents observed administraiton times med error rate. Findings include: During observation medication adminis | pplement. TMA-D stated she supplement to R130. 7 HUCG stated being ering nutritional supplements ad never ordered Boost pplement for R130. 0 p.m. RD-A, who had 5/16, RD note was interviewed the facility for a week and no parameters for staff to nister the "when necessary" ent to R130. RD-A also not received the supplement of the physician on 10/7/16. E OF MEDICATION ERROR MORE sure that it is free of the supplement of the physician or greater. NT is not met as evidenced ion, interview and document ailed to ensure medications to 3 of 7 (R96, R82, R111) | F 33 | | dures ring d nd has oriate. wed for | 12/16/16 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI IER/CLIA

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|---------------------|---|---|----------------------------|
| | | 245255 | B. WING | | 11/03/2016 | |
| | ROVIDER OR SUPPLIER Y CARE CENTER ON | I HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 332 | residents and the forwere observed: On 11/2/16, at 3:55 administer R96 one calcium carbonate. orders dated 11/1-1 was to receive 1250 At 4:05 p.m. RN-D R82 one tablet of the review of physician revealed the reside of senna plus. At 5:07 p.m. RN-D cart a bottle of Tyle tables. RN-D stated dosage, replaced the removed a bottle of asked what dose of RN-D stated R111 r RN-D then placed to into the medication to R111 orders dated 11/1-1 was to receive Tyle total of 1000 mg. The facility's 12/12 | p.m. RN-D was observed to tablet of 500 mg (milligram) A review of the physician 1/30/16, revealed the resident may be more than the laxative senna plus. A orders dated 11/1-11/30/16, and was to receive two tablets removed from the medication mol Extra Strength 500 mg I R111 did not receive that the bottle in the cart and Tylenol 325 mg tablets. When Tylenol R111 was to receive, we tablets of Tylenol 325 mg cup and administered the control A review of the physician 1/30/16, revealed the resident mol 500 mg, two tablets for a revised policy titled | F 332 | the potential to be affected. Additional education regarding accommedication administration will be provided to RN-D. Mandatory education will be provided staff responsible for passing medication December 1st, 6th, and 7th, 201 will include the include the Policy for Administering Medications. Audits of medication administration occur 3x/week on each floor, on alternating shifts, through January 2017. All audit results will be report the Quality Council in January and Quality Council shall determine if an ongoing audit schedule is required. The Director of Nursing /designee stresponsible for monitoring compliar. Date of completion: December 16, | ed for ations 16, this or will 24, ted to the n shall be nee. | |
| F 412 SS=D | Administering Medi were to "be adminis orders." 483.55(b) ROUTINI SERVICES IN NFS | cations, indicated medications stered in accordance with | F 412 | | 1 | 12/16/16 |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ` ' | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---|--|--|-------------------------------|--|
| | | 245255 | B. WING | | 1. | 1/03/2016 | |
| | PROVIDER OR SUPPLIER TY CARE CENTER ON | I HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CO 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 412 | an outside resource §483.75(h) of this p covered under the services to making appointment transportation to an must promptly refer damaged dentures This REQUIREMENT by: Based on observative review, the facility for the service with the service the facility of the service with the service the facility of the service with the service the facility of the service with the service | e, in accordance with art, routine (to the extent State plan); and emergency neet the needs of each ecessary, assist the resident in its; and by arranging for d from the dentist's office; and residents with lost or to a dentist. NT is not met as evidenced ion, interview and document ailed to ensure dentist were implemented for 1 of 3 in identified dental needs. 9 p.m. R75 was observed to A review of R75's record resident had been seen by a | F 4 | The facility has polices and place to provide or obtain from resource, in accordance with this part, routine (to the externation of the state plan); and expendent in making appointment arranging for transportation the dentist is office; and mure fer residents with lost or discontinuous dentitation and deemed approximation of the policy titled Dental Service and deemed approximation of the policy titled Dental Service and deemed approximation of the policy titled Dental Service and deemed approximation of the policy titled Dental Service and deemed approximation of the policy titled Dental Service and deemed approximation of the policy titled Dental Service and deemed approximation of the policy staff. A copy of the polic | om an outside h 483.75(h) of the 483.75(h) of the tovered emergency needs of each assist the nents; and by to and from ust promptly lamaged vices was opriate. cility 11/20/16 ne e were made e Consent ation for the f he visited. A opy of the to the | e of h | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|---|---|----------------------------|
| | | 245255 | B. WING _ | | 11/03/2016 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | , | 0,-010 |
| CERENIT | Y CARE CENTER ON | HUMBOLDT | | 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 412 | information services had a new dental vi the dentist's 3/31/15 director of HIS state and a new dental co. The facility's 11/30/ Services revealed r | ge 31 s (HIS) stated R75 had not sit scheduled to follow up on 5 recommendations. The ed R75 had "slipped through" onsent had not been obtained. 10, revised policy titled Dental esidents were to receive ses upon admission, yearly | F 41 | All current residents have had an a completed to verify consents for De Services and date of last Dental vis Based on the audit results, any res who did not have a dental visit with past year will be offered to have a visit scheduled. Any resident who not have a signed consent, will be contacted by Health Information Services/designee to obtain conservices/designee to obtain conservices will be added the Care Conference checklist to be reviewed at least question of the Quality Council in January 24 2017. All audit results will be report the Quality Council shall determine ongoing audit schedule is required. Director of Health Information Services/designee shall be responsimonitoring compliance. | ental sit. ident in the dental does nt. dental ence larterly. th, ted to 7 and if an . The | |
| F 431 SS=D | 483.60(b), (d), (e) [LABEL/STORE DR | DRUG RECORDS, UGS & BIOLOGICALS | F 43 | Date of completion: December 16, | 2016 | 12/16/16 |
| | a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order | nploy or obtain the services of cist who establishes a system t and disposition of all sufficient detail to enable ancion; and determines that drug r and that an account of all maintained and periodically | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | | | |
|--|---|--|---|------------|--|---|---------------------|---|---|----|----------------------------|
| 245255 | | | B. WING | | | 11/03/2016 | | | | | |
| | PROVIDER OR SUPPLIER | | | 5 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 12 HUMBOLDT AVENUE AINT PAUL, MN 55107 | • | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | X | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 431 | labeled in accorda professional principal appropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and permanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districts. | als used in the facility must be note with currently accepted oles, and include the sory and cautionary he expiration date when State and Federal laws, the fall drugs and biologicals in the note in the note when he will be all drugs and biologicals in the sunder proper temperature it only authorized personnel to be keys. Tovide separately locked, and compartments for storage of the in Schedule II of the rug Abuse Prevention and is and other drugs subject to the facility uses single unit in the facility uses single unit in the ninimal and a missing dose can | F4 | .31 | | | | | | | |
| | by: Based on observareview, the facility were properly labe and R102) using ir of 9 residents (R7) floor west wing. Findings include: R69 had a discontiventolin inhaler to | NT is not met as evidenced ation, interview, and document failed to ensure medications led for 2 of 8 residents (R69 shalers on the third floor, and 1 using insulin on the second and the physician order for a be used as needed, in place of the content of the second the secon | | | The facility has policies and proce in place to employ or obtain the se of a licensed pharmacist who estal a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accura reconciliation; and determines that records are in order and that an accord all controlled drugs is maintained periodically reconciled. Drugs and biologicals used in the fimust be labeled in accordance with | rvices plishes n ate drug count d and acility | | | | | |

| , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------|--|---|--|---|--|--|-------|----------------------------|
| | 245255 | | B. WING | | 11/03/2016 | | | |
| | PROVIDER OR SUPPLIER | N HUMBOLDT | į | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | , | | | |
| (X4) ID PREFIX TAG | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 431 | observation on 11/0 R69's inhaler in the cart. It was stored is labeled in marker winhaler and bag lad indicate medication date, resident's nar and any applicable. In an interview on registered nurse (Fishould have had a interview on 11/03/10 nursing (DON) conhave a pharmacy late. R102 had a current Diskus inhaler. Obsthat the facility store third floor west medistored inside a plas with the resident's is top of the diskus inhad been used, but indicating when the from the foil storag lacked a pharmacy. When asked about 11/02/16 at 10:59 a assistant (TMA-C) unlabeled Advair and interview on 11/1/10 practical nurse (LP Advair needed to he 11/03/16 at 2:19 p.1/10. | e order was discontinued, 02/16 revealed the facility kept of third floor east medication inside a plastic bag, and with the resident's name. The sked a pharmacy label to in name, strength, expiration me, route of administration, instructions and precautions. 11/02/16 at 10:40 a.m., instructions and precautions and label attached. In an and a servation of the dication of the inhaler was stic bag, and labeled in marker name. The dose indicator on dicated that the medication at the inhaler lacked a date are medication was removed a pouch. The inhaler also relabel. 11/02/16 at 11:11 a.m., licensed way and order a new one. In 102/16 at 11:11 a.m., licensed N-B) confirmed that R102's ave a pharmacy label. On m., the DON said that the ded to be dated for disposal 30 are apparted for disposal 30. | F 431 | currently accepted processional principles, and include the appropaccessory and cautionary instruct and the expiration date when appropriate and control and to the keys. The facility must provide separate locked, permanently affixed compartments for storage of condrugs listed in schedule II of the Comprehensive Drug Abuse Prevand Control Act of 1976 and other subject to abuse, except when the uses since unit package drug dissystems in which the quantity stominimal and a missing does can readily detected. The policy titled Labeling Medication reviewed and deemed appropriate R69 s discontinued inhaler was from the medication cart. R102 s Advair Discus Inhaler is and was dated when opened. R7 has a new vial of Novolog insis labeled with the date opened. | tions, olicable. deral rugs and of the under permit expermit expermit experience access ely trolled vention redugs experience facility tribution red is be tions has opriate. Ins was experience access experience access ely trolled vention redugs experience facility tribution red is be tions has opriate. Ins was experience access exp | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING | | 11/03/2016 | | |
| | PROVIDER OR SUPPLIER TY CARE CENTER OF | N HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 431 | Diskus directed usemonth after you remark the remark produced in the second floor we lacked a date that in the remark the | d Guidelines For Use Of Advairers to discard Advair Diskus 1 move it from the foil pouch. hysician order for Novolog scale. Observation on the facility stored R7's insulin in est medication cart. The insulin indicated when it was opened. In insulin left in the vial, medication had been used. In the missing open date in an 16 at 12:28 p.m., RN-A said ate opened was written on a in vial. On 11/03/16 at 2:19 firmed that the facility policy te insulin after it was opened. | F 43 | All inhalers have been checked to a they are labeled appropriately. Adv. Discus Inhalers have been checked verify they are labeled appropriately are dated when opened. All insulin shave been checked to ensure labels are present and date opened are present. Mandatory education on labeling of medications and dating open vials inhalers will be provided on Decem 2016 to all licensed nursing staff ar Trained Medication Assistants that administer medications. Education will include review of the policies titled Labeling Medications Dating Medications as well as the expectation to follow these policies removal of medications from the medication cart when they are discontinued or changed. Audits for labeling of medications a dating open vials will occur 3x/weel each medication cart through Janua 2017. All audits will be reported to Quality Council in January and the Council shall determine if ongoing a scheduling is required. The Director Nursing or designee shall be respofor monitoring compliance. | air d to y and and s and ber 1, nd and and and cly on ary 24, the Quality audit or of | | |
| F 441 SS=E | 483.65 INFECTION SPREAD, LINENS | N CONTROL, PREVENT | F 44 | Date of completion: December 16, | | 12/16/16 | |

| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT SITREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 PROVIDERS PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY PUL) REGULATORY ON LSC DENTIFYING INFORMATION) 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 prophibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if 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. | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| CERENTY CARE CENTER ON HUMBOLDT (X41) D (X41) D (X41) D (X41) EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 and 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 infection. (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 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 | | | 245255 | B. WING | | | 11/03/2016 | |
| FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 | | | N HUMBOLDT | | 5 | 12 HUMBOLDT AVENUE | | |
| 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 | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE | COMPLETION |
| | F 441 | The facility must es Infection Control Presafe, sanitary and of the help prevent the of disease and infection Control The facility must es Program under white (1) Investigates, coin the facility; (2) Decides what personal be applied to (3) Maintains a receations related to in (b) Preventing Spresconding Spresconding the facility must determine that a reprevent the spreadisolate the resident (2) The facility must communicable disest from direct contact direct contact will treat (3) The facility must hands after each dhand washing is incorposessional practice (c) Linens Personnel must hat transport linens so | stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction. Il Program stablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. In additional control Program esident needs isolation to of infection, the facility must are as or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their irect resident contact for which dicated by accepted in indicated by accepted in indicated in its process and its process | F | 141 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | , , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING | | 11/03/2016 | | |
| | PROVIDER OR SUPPLIER TY CARE CENTER OF | N HUMBOLDT | , | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE | |
| F 441 | by: Based on observareview, facility failed prevent the spread glucose monitoring R56, R63, R54) observed for the prevent the spread glucose monitoring; for han 3 residents (R57, For daily living; and to observed during must be found to be found | tion, interview, and document d to implement procedures to of infection during blood for 4 of 4 residents (R10, served for blood glucose dwashing during cares for 3 of R63 R54) reviewed for activities or 2 of 7 residents (R96, R62) edication administration. a.m. during a blood glucose ation, registered nurse (RN)-G ash hands with hand sanitizer, a blood glucose monitoring nedication cart and walk down om. RN-G knocked on the redication cart and walk down om. RN-G knocked on the redication cart to R10. RN-G placed meter, alcohol wiped R10's blood sample. RN-G tossed a left room, placed glucometer edication cart, tossed lancet (a real instrument) into sharps remaining garbage, and placed in bottom drawer of N-G washed her hands with reg was observed to not | F 441 | The facility has policies and proce in place to establish and maintain Infection Control Program designe provide a safe, sanitary and comforment and to help prevent the development and transmission of and infections. (a) Infection Control Program - The facility must establish an Infection Program under which it (1) Invecontrols and prevents infections in facility; (2) Decides what procedur such as isolation, should be applied individual resident and (3) Maintained record of incidents and corrective related to infections. (b) Preventing the spread of Infection (1) When the Infection Control Procedetermines that a resident needs it to isolate the resident (2) The fact must prohibit employees with a communicable disease or infected lesions from direct contact with resor their food, if direct contact with resor their food, if direct contact with resor their food, if direct contact will the disease. (3) The facility must staff to wash their hands after each resident contact for which hand was indicated y accepted profession practice. (c) Linens Personnel must handly process and transport linens so as prevent the spread of infection. A policy titled Glucometer Cleaning | an ed to ortable he disease ne Control stigates, a the es, ed to an ains a actions ction - ogram solation sility diskin sidents cansmit require h direct ashing al | | |

| AND PLAN OF CORRECTION IDENTIFICATION NOWIBER. A. BUILDING | COMPLETED |
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| 245255 B. WING | 11/03/2016 |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT STREET ADDRESS, CITY, STATE, ZIF 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIVE ACT | ION SHOULD BE COMPLÉTION HE APPROPRIATE |
| 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 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 | Jse has been sident having individual use. shing/Hand red and deemed itled Facility is been reviewed es Blood rovided with their he glucometer on the endations and ometer Cleaning. all licensed Medication roting the procedure for cations will be st, 6th and 7th, and review of roleaning and as the ese policies and sax/weekly by Clinical crify staff is seed on endations and endations and endations and |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245255 | B. WING | | | 11/0 | 3/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER O | | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 12 HUMBOLDT AVENUE 6AINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL PR CONTROL OF THE PROPERTY OF | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 441 | Support Program (Assure Platinum B 2014 revealed: "Ordisinfecting can be commercially avail disinfectant deterg wipes act as both a blood is visibly premust be used, one wipe to disinfect package or contain package. If wipe is remove excess liquon front, back, and METER IN A WIPE liquid in the test stimeter. Step 4 Let manufacturer's ins CMS guidelines reneed to be cleaned use. It is our interpassigned meters in disinfected Disin with an EPA registing germicide that is a settings It is imprestablish a program program should invand disinfection of During observation 11/3/16, at 8:31 a walked into bathrohands for 10 secondates. | Comprehensive Service & Cleaning and Disinfecting your shood Glucose Meter dated May potion 1 Cleaning and e completed by using a able EPA-registered ent or germicide wipe. Many a cleaner and disinfectant. If sent on the meter, two wipes wipe to clean and a second Step 2 Remove wipe from her. Follow instructions on a very wet, gently wring wipe to uid. Step 3 Wipe down meter it sides. DO NOT WRAP THE E. Take extreme care not to get rip and key code ports of the | F 4 | 141 | Standard Precautions will be provided December 1st, 6th, and 7th, 2016. Education will include the review of titled Hand washing/Hand Hygiene expectation of when to wash hands the length of time required for proposashing, and when to wear and regloves. Hand washing audits reflecting observation during medication administration with review of medicities dispensing will be completed 3x/weall units/all shifts through January 2017. Hand washing audits and observation when providing residel will be completed daily on all units/shifts for 2 weeks and then 3x/wee all units/all shifts through January 2017. All audits results will be reported Quality Council in January and Quality Council shall determine if of audit schedules are required. The of Nursing/designee is responsible monitoring compliance. Date of completion: December 16, | f policy, the sand her hand move cation eekly on 24, orted to the ingoing Director for | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|------------------------|---|-------------------------------|----------------------------|
| | | 245255 | B. WING | · · · · · · · · · · · · · · · · · · · | 11/ | /03/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER ON | I HUMBOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 441 | was unable to find a garbage and left room on 11/3/16, at 8:39 applied clean glove indicated it was not protectors, informed dressed, then wash NA-F applied R57's rolled R57 toward wamount bowel move garbage and applied R57's pant legs up toward resident. NA elevated head of be walker seat and put R57, put transfer be into bed, strapped belowered bed and sa transferred R57 to sand removed transform flushed thands for 10 second clean gloves, walke R57's nightgown, all eyeglasses. NA-F to dirty linens. NA-F was R57's dentures. R5 NA-F removed gloves, whocked on door, edrink of water. NA-F dentures in R57's millinens and held bag room. About five feer removed her gloves wheeling R57 down | coked for cleansing wipes, any, removed gloves, tossed in om. a.m. NA-F walked into room, as, checked R57's pad and wet. NA-F applied R57's leg d R57 she would get her ed R57's face with wash cloth. socks, pants, removed pad, vindow, wiped away small ement, tossed pad into d clean pad. NA-F pulled and pulled wheelchair over and pad to the money of them on R57. NA-F sat up elt on, transferred R57 back belt, laid R57 back down, at R57 up again. NA-F sitting position in wheelchair er belt. NA-F walked into coilet, removed gloves, washed dos, wiped hands, applied d back into room, removed oplied shirt, sweater and wisted shut garbage bag with alked into bathroom to clean asked for a drink of water. The saked for a drink of wate | F 4 | 41 | | |

| - | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|--------|---|------|---|--|
| | | 245255 | B. WING | | | 11/(| 03/2016 | |
| | PROVIDER OR SUPPLIER | I HUMBOLDT | | 512 HU | T ADDRESS, CITY, STATE, ZIP CODE JMBOLDT AVENUE PAUL, MN 55107 | | <i>-</i> , | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 441 | her hands after perishe washed her hand the bathroom, NA-Fremember" and ind handwashing time washing (ADON) stanursing (ADON) stanursing assistant shands after peri-car and dressing the reexpectation was to Facility Standard Probecember 2007 revinclude the following after removing gloves, as necessaresident to prevent body site to another site to a "clean" one Facility Handwashin August 2014 reveal hand rub containing alternatively, soap (non-antimicrobial) a situations: h. Before contaminated body during resident care or bodily fluids; Wather hands with so creating friction to a 15 seconds (or long the situations). | a.m. NA-F stated she washed i-care. When asked how long had after removing gloves in stated she "could not icated did not know proper was 20 seconds. 2 p.m. assistant director of ated her expectation was nould remove gloves and wash he before continuing with cares sident. ADON stated wash hands for 20 seconds. Tecautions policy dated wash hands for 20 seconds. Tecautions policy dated vealed: "Standard precautions g practices: d. Wash hands es (see below). e. Change ry, during the care of a cross-contamination from one r (when moving from a "dirty" e)." Tag/Hand Hygiene policy dated ed: "7. Use an alcohol-based g at least 62% alcohol; or, antimicrobial or and water for the following | F 4 | 41 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|--|------------------------------------|----------------------------|
| | | 245255 | B. WING | | 11 | /03/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER O | | | STREET ADDRESS, CITY, STATE, 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CEACH CORRECTIVE ACCURATE ACC | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 441 | 11/2/16, at 9:55 a. came to the room, wash hands, turne put hands under the seconds, NA-A turned hands, dried hand donned a pair of groom at the same use hand sanitizer gloves. R63 was incontine movement which is cleanse away the provide perineal cleanse away the provide perin | age 41 In of R63's morning cares on m. nursing assistant (NA)-A went into the bathroom to ad on the water with bare hands, he water stream, after 2 ned off the water with bare is with a paper towel and loves. NA-B came into the time and did not wash hands or before donning a pair of a large loose bowel NA-A and NA-B used wipes to bowel movement and to eansing. NA-A and NA-B were forth a tube of protective ring contaminated gloves, ing the tube of protective in then was put back into R63's thout being sanitized. NA-A and a contaminated gloves but did the hands before donning ves. After completing cares, and to wash hands for 5 seconds. In did sanitizer in the room and and sanitizer in the room and and sor while singing the ABC's. 14 a.m. trained medication came into the room to do a nitor for R63. TMA-A did not ands and donned a pair of tained the sample of blood, as and left the room without and hands. TMA-A did not | F4 | 41 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|----------------------|---|-------------------------------|----------------------------|
| 245255 | | B. WING _ | | 11. | 11/03/2016 | |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | | STREET ADDRESS, CITY, STATE, ZIP C 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 441 | to TMA-B on anoth glucometer using a bin. TMA-B wiped t with the sanitizing with the blood was gloves and proceed and running water interviewed at 10:2 facility handwashing while singing happy cart, TMA-B proced and wiped off the gleft the glucometer medication cart. On 11/2/16, at 3:55 medication administration administration and the medication administration and then into the meds were then adwashing hands RN cart and began sett RN-D punched out medication metoprotheir hand and placemed cup. The med R62 and afterwards Interview at 4:00 p. hands were washed | eter and took the glucometer er wing. TMA-B sanitized the wipe from a purple topped he glucometer for 15 seconds | F 44 | | | |

| STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---------------------|---|--------|-------------------------------|--|
| | | 245255 | B. WING _ | | 11/ | /03/2016 | |
| | CERENITY CARE CENTER ON HUMBOLDT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| F 441 | August 2014 reveal hand rub cdntaining alternatively, soap (non-antimicrobial) a | ng/Hand Hygiene policy dated led: Use an alcohol-based g at least 62% alcohol; or, | F 44 | 1 | | | |
| F 458 SS=B | LEAST 80 SQ FT/F Bedrooms must me per resident in mult | DROOMS MEASURE AT RESIDENT easure at least 80 square feet iple resident bedrooms, and at et in single resident rooms. | F 45 | 8 | | 12/16/16 | |
| | by: Based on observate failed to provide at resident in multiple | NT is not met as evidenced ion, and interview, the facility least 80 square feet per resident bedrooms for three ms affecting five residents. | | See Attached | | | |
| | Resident double oc observed to be app instead of the requi occupancy in rooms On 11/3/16, at 1:00 provided document 223 and 326 were of acknowledged a wardouble occupancy i | cupancy square footage was roximately 155 square feet red 160 square feet for double s 222, 223, and 326. p.m. the administrator ation indicating rooms 222, double occupancy rooms and aiver was in place, allowing n the 155 square foot double egulation of 160 square feet in rooms. | | | | | |
| | Resident's residing | in those rooms did not offer | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|---|---------------------|---------------------|--|-------------------------------|----------------------------|
| | 245255 | B. WING | | 11/0 | 03/2016 |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUM | BOLDT | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | , | |
| (X4) ID SUMMARY STATEMEN' PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN | BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 458 Continued From page 44 complaints regarding the | size of the rooms. | F 458 | | | |



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

which?

Administrator/ CEO

Cerenity Care Center- Humboldt

76755026

PRINTED: 11/30/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 **B WING** 11/03/2016 245255 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **512 HUMBOLDT AVENUE CERENITY CARE CENTER ON HUMBOLDT** SAINT PAUL, MN 55107 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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 (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

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

PRINTED: 11/30/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | FIPLE CONSTRUCTION NG 01 - Main Building 01 | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|--|---|------------------------------|-------------------------------|--|
| | 245255 | | B. WING | | | 11/03/2016 | |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| K 000 | DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or properties of the correct the defice 3. The name and/oresponsible for corprevent a reoccurr (Cerenity Care on The building was times. The original 1960 and was detection. In 19 was determined to construction. Because the 1 addition are construction and nullowed for existing surveyed as one building is full fire alarm system detection and space monitored for autonotification. | Suite 145 -5145, or state.mn.us and n@state.mn.us PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. Humboldt) is a 4-story building constructed at 2 different building was constructed in ermined to be of Type II(222) 70, addition was constructed be of Type II(222) iuse the original building and of the same type of neet the construction type g buildings, the facility was | KO | | | | |

PRINTED: 11/30/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | | E CONSTRUCTION 01 - Main Building 01 | (X3) DATE SURVEY COMPLETED | | |
|--|-----------------------|---|--------------------|------|---|-------------------------------|----------------------------|--|
| | 245255 B. WING | | | 11/0 | 03/2016 | | | |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | | 51 | REET ADDRESS, CITY, STATE, ZIP CODE 12 HUMBOLDT AVENUE AINT PAUL, MN 55107 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| K 211 SS=D | | | | 211 | | | 11/4/16 | |
| | | | | | Door will remain unlocked. The lobeen removed from the door. Date Completed: 11-4-16 | ck has | | |
| | the staff and visito | ctice could affect the safety of all rs within this compartment. ctice was confirmed by the ce Director at the time of | | | | | | |

PRINTED: 11/30/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|---|--|-------------------------------|----------------------------|
| | | 245255 | B. WING | | | 11/0 | 3/2016 |
| | NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | | EET ADDRESS, CITY, STATE, ZIP CODE HUMBOLDT AVENUE NT PAUL, MN 55107 | | |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | D BE | (X5) COMPLETION DATE |
| K 351 SS=D | Spinkler System - 2012 EXISTING Nursing homes, ar construction type, approved automati accordance with N Installation of Sprir In Type I and II cor measures are perr sprinkler protection or local regulations In hospitals, sprink closets of patient sof the closet does sprinkler coverage required by NFPA Sprinkler Systems 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, This STANDARD Spinkler System - 2012 EXISTING Nursing homes, ar construction type, approved automat accordance with N Installation of Sprir In Type I and II comeasures are peri sprinkler protection or local regulations. In hospitals, sprink closets of patient sof the closet does sprinkler coverage required by NFPA Sprinkler Systems | and hospitals where required by are protected throughout by an ic sprinkler system in FPA 13, Standard for the hkler Systems. Instruction, alternative protection mitted to be substituted for in specific areas where state is prohibit sprinklers. Iters are not required in clothes sleeping rooms where the area not exceed 6 square feet and iterocers the closet footprint as 13, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5, 9.7, 9.7.1.1(1) is not met as evidenced by: Installation and hospitals where required by are protected throughout by an ic sprinkler system in IFPA 13, Standard for the inkler Systems. Instruction, alternative protection mitted to be substituted for in in specific areas where state is prohibit sprinklers. Installation of seleping rooms where the area not exceed 6 square feet and it ecovers the closet footprint as 13, Standard for Installation of 5. | K3 | | Sprinkler head on 3rd floor was on November 4, 2016. Cleaning of sprinkler heads will be added to the schedule and be cleaned on a quas-needed basis. Completed 11-4-16 | of he PM | 11/4/16 |

PRINTED: 11/30/2016 FORM APPROVED OMB NO. 0938-0391

| | | | | | | TE SURVEY MPLETED |
|--|--|--|---|--|--|--|
| | 245255 | B. WING | | | 11. | /03/2016 |
| NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER ON HUMBOLDT | | | 512 | HUMBOLDT AVENUE | | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | | | (EACH CORRECTIVE ACTION : | SHOULD BE | (X5) COMPLETION DATE |
| Continued From pa | age 4 | K | 351 | | | |
| on 11/3/16, based | on observation and interview | | | | | |
| | | | | | | |
| | | | | ä | | |
| Facility Maintenan discovery. | ce Director at the time of | | | | | |
| NFPA 101 Electric and Extens | al Equipment - Power Cords | K | 920 | | | 11/4/16 |
| Extension Cords Power strips in a pused for compone | patient care vicinity are only nts of movable | | | | | |
| (PCREE) assembly qualified person 10.2.3.6. Power s may not be used f electronics), except | les that have been assembled neel and meet the conditions of trips in the patient care vicinity or non-PCREE (e.g., personal of in long-term care resident | | | | | |
| PCREE meet UL strips for non-PCF (outside of vicinity care rooms, powe | 1363A or UL 60601-1. Power REE in the patient care rooms) meet UL 1363. In non-patient r strips meet other UL | | | | | |
| precautions. Exte substitute for fixed Extension cords u | nsion cords are not used as a l wiring of a structure sed temporarily are removed | | | | | |
| | PROVIDER OR SUPPLIER Y CARE CENTER O SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From portion of the residents, staff compartment. This deficient practive residents, staff compartment. Electrical Equipment Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb by qualified person 10.2.3.6. Power smay not be used for electronics), except rooms that do not PCREE meet UL strips for non-PCF (outside of vicinity care rooms, power standards. All power strips in cords upprecautions. Extension cords upprecautions. Extension cords upprecautions. Extension cords upprecautions cords up | 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. NFPA 101 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 (PCRE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient 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 emoved immediately upon completion of the purpose for | ROUNTIER ON HUMBOLDT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 K Continued From page 5 Page 7 Continued From page 7 Continued From page 7 Continued From page 8 K Continued From page 7 Continued | TORRECTION PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 K 351 Continued From page 4 Continued From page 4 K 351 Continued From page 4 Continued From page 4 K 351 C | TONITION OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF SUPPLIER PROVIDER OR SUPPLIER TY CARE CENTER ON HUMBOLDT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. NFPA 101 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 way 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 U. 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 | A BUILDING 01 - MAIN BUILDING 01 245255 B. WING TOTAL STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. NFPA 101 Electrical Equipment - Power Cords and Extension Cords Electrical Equipment - Power Cords and Extension Cords Electrical Equipment and meet the conditions of 10,2.3.6. Power strips in the patient care resident (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10,2.3.6. Power strips in the patient care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363.0 or UL 60601-1. Power strips for non-PCREE (e.g., personal electronics), power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords are not used as a substitute for fixed wiring of a structure. |

Event ID: 8SV721

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | IPLE CONSTRUCTION NG 01 - Main Building 01 | | E SURVEY IPLETED |
|---|---|--|---------|---|-----------------------------------|----------------------------|
| | | 245255 | B. WING | | 11/ | 03/2016 |
| | PROVIDER OR SUPPLIEF | | | STREET ADDRESS, CITY, STATE, 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | ZIP CODE | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) TAG CROSS-REFERENCED TO THE APPROPRIATION (DEFICIENCY) | | | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| K 920 | (NFPA 70), 590.3(This STANDARD Electrical Equipm Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb by qualified perso 10.2.3.6. Power smay not be used electronics), excerooms that do not PCREE meet UL strips for non-PCI (outside of vicinity care rooms, power standards. All poprecautions. Extension cords up immediately upon which it was insta 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3 On facility tour be on 11/3/16, based revealed that the An extension cordused as permane. This deficient prathe residents, sta compartment. | B), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 is not met as evidenced by: ient - Power Cords and coatient care vicinity are only ents of movable ed electrical equipment eles that have been assembled nnel and meet the conditions of estrips in the patient care vicinity for non-PCREE (e.g., personal pt in long-term care resident use PCREE. Power strips for 1363A or UL 60601-1. Power REE in the patient care rooms (f) meet UL 1363. In non-patient er strips meet other UL wer strips are used with general ension cords are not used as a d wiring of a structure. Used temporarily are removed (completion of the purpose for lled and meets the conditions of (D), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 tween 12:30 AM and 4:30 PM d on observation and interview findings include: d was found in office 102 being | K 92 | Extension cord was rer 102 on November 7, 20 | | |

PRINTED: 11/30/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) F AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01 | (X3) DAT | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--------------------|---|--|-------------------------------|--|
| | | 245255 | B. WING | | 11 | /03/2016 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | DE | | |
| CERENIT | TY CARE CENTER ON | NHUMBOLDT | | 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | |
| (X4) ID PREFIX TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | Y (FACH CORRECTIVE ACTION S | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| | Continued From pa | | KS | DEFICIENCY) | | | |
| | | | | | | | |

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



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

Cerenity Care Center On Humboldt November 18, 2016 Page 2

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 Meeth

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

PRINTED: 11/28/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00538 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **512 HUMBOLDT AVENUE CERENITY CARE CENTER ON HUMBOLDT** SAINT PAUL, MN 55107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

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/in fobul.htm> The State licensing orders are delineated on the attached Minnesota

notice of assessment for non-compliance.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 11/27/16

STATE FORM If continuation sheet 1 of 46 8SV711

TITLE

(X6) DATE

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES

| STATEMENT OF DEF | | (X1) PROVIDER/SUPI | | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|--|--|--|---------------------------|--|-------------------|--------------------------|
| | | | | A. BUILDING: | | | |
| | | 00538 | | B. WING | | 11/0 | 3/2016 |
| NAME OF PROVIDER | R OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENITY CARE | E CENTER ON | N HUMBOLDT | | BOLDT AVEN .UL, MN 551 | | | |
| | CH DEFICIENC | TEMENT OF DEFICIEN / MUST BE PRECEDED SC IDENTIFYING INFOR | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| Depart you elsis neces enter the text. You state his complet correct Minness on On Occurrey above orders electron reviews they will be stated assign. Nursing The assign nursing the State He correct finding after the eviden are the Time purpose. | ectronically. essary for State he word "cor- ou must then icensure pro- etion date, the ted prior to e sota Departm tober 31, No ors of this De provider and are issued. Inic plan of ce ed these ord ill be comple sota Departm ate Licensing I software. Ta ed to Minnes g Homes. esigned tag in n entitled "II fulle out of ce places the "I tion order. The s which are in the statement ce by." Follow estatement c | Although no plan of the Statutes/Rules rected" in the box indicate in the elecess, under the hele date your orders lectronically subment of Health. I the following correction that you ers, and identify the correction Orders ag numbers have lectronically subment of Health is described to the correction of the second of Deficiencies to Comply" portion is column also inconviolation of the second of Correction of Correction of the second of Correction of Correcti | of correction, please available for ectronic eading will be itting to the ection your have ne date when occumenting susing ocen frules for the far left estate d in the column of the cludes the estate statute met as a findings ion and G OF THE S, ION." THIS | 2 000 | | | |

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 2 of 46 8SV711

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|----------------------|--|-------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | _ | |
| CERENIT | TY CARE CENTER ON | I HUMBOLDT | BOLDT AVENUL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE | (X5) COMPLETE DATE |
| 2 000 | Continued From pa | ge 2 | 2 000 | | | |
| | THIS WILL APPEA | R ON EACH PAGE. | | | | |
| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | | | | |
| 2 565 | MN Rule 4658.0409 Plan of Care; Use | 5 Subp. 3 Comprehensive | 2 565 | | | 12/16/16 |
| | | omprehensive plan of care personnel involved in the | | | | |
| | by: Based on observati review, the facility fa plan for 1 of 3 resid dental needs; for required staff assist | ent is not met as evidenced on, interview and document ailed to implement the care ents (R75) with identified of 3 residents (R63) who tance with oral care, and for 2, R24) who required ontinent care; and | | See above. | | |
| | Findings include: | | | | | |
| | R75 on 11/01/6, at have missing teeth. | 12:09 p.m., was observed to | | | | |
| | | ed 8/29/16, identified R75 as missing teeth and indicated dentist as needed. | | | | |
| | (HUC)-G reviewed had been to the der | 9 p.m. health unit coordinator R75's record and found R75 ntist on 3/31/15, and the nended a return visit six | | | | |

Minnesota Department of Health

STATE FORM 8SV711 If continuation sheet 3 of 46

Minnesota Department of Health

| | | | E SURVEY PLETED | | | |
|--------------------------|---|--|--|---|----------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 03/2016 |
| | PROVIDER OR SUPPLIER | HUMBOLDT 512 HUM | DDRESS, CITY, S BOLDT AVEN AUL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| 2 565 | months later. No refound in the record time by HUC-G. R63, document rev Plan, dated, 3/20/1 oral cares. The doc Assessment (CAA) "Resident is NPO (ITF (tube feeding) Scares-mouth swabs white/yellow coating treated with nystatin appear to be thrush discomfort, no blee and coating is only cheeks. Per wife hastarted TF. Staff to cares and will refer Document review of directed nursing stated to have a coating on the lips and tongue heavy coating on the that it was botherso present and stated provide oral care expre-moistened swadrawers currently a having to ask for mot think the oral catwo hours. During continuous of 11/2/16, from 7:30 and 11/2/16, from 7:30 | turn visit to the dentist was and this was confirmed at this and this was confirmed at this eiew of the form titled, Care 5, read, total assistance with tument titled, Care Area dated 3/10/16, read, nothing per oral) and receives staff assist with oral and cover tongue, had been to but no effect-does not an Resident denies any ding, or open areas present, on tongue-not sides of as been present since he continue to assist with oral to dental prn." If the form titled, Care Sheet, aff for mouth swabs every two on 11/1/16, at 3:00 p.m. R63 and a white moist substance on a R63 was observed with a see tongue and did complain of the facility is suppose to very two hours using the best but there are none in the not F-B verified frequently ore swabs because F-B did ares were being provided every observations of R63's care on a.m. through 12:15 p.m.: R63 a lying in bed and there were | | | | |

Minnesota Department of Health

STATE FORM 88V711 If continuation sheet 4 of 46

Minnesota Department of Health

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|--------------------------|--|-------------------|--------------------------|
| | | 00538 | B. WING | | 11/03 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENI | TY CARE CENTER ON | I HUMBOLDT | BOLDT AVEN UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 4 | 2 565 | | | |
| | nursing assistants (room with R63 provinterviewed, verified provided to R63 yet the oral care now. Document review of dated revised October the resident's care needs of the reside During an interview p.m. verified the fact provide oral care expressed 10/10/16, i | with RN-A on 11/2/16, at 1:30 cility expectation was to | | | | |
| | the care plan was followed of bladder and this goal, the care planting every two hone. | or R31 to maintain current blan directed staff to provide hours with extensive assist of | | | | |
| | 11/03/16, directed of | care staff to provide toileting h extensive assist of one. | | | | |
| | 8:22 a.m. until 11:2: leaving bedroom us reclining chair in frowas observed movi sitting in the reclining room. the reclining chair chours. At 11:24 a.m. | observation on 11/03/16 from 4 a.m., R31 was first seen sing rolling walker to reach a ont of the nurses' station. R31 ing back and forth between ng chair, and sitting at a table R31 remained sitting either in or the dining room for three in R31 got up from the table ne hall toward bedroom using | | | | |

Minnesota Department of Health

STATE FORM 88V711 If continuation sheet 5 of 46

Minnesota Department of Health

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|--------------------------|--|-------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENI | TY CARE CENTER ON | N HUMBOLDT | BOLDT AVEN UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 565 | the rolling walker. To dark marking on it. brief and dress and wet my pants, I wet the laundry?" At this down to R31's bedrourse helped R31 gand gave the medic staff helped with to "Sometimes." In interview on 11/0 nurse (RN-E) said I encouraged toileting one with activities of the control | The back of R31's dress had a R31 got to bedroom, took off I seemed distraught saying, "I my pants. Can you put this in stime the nurse had come room to give medications. The put on a clean brief and dress, cations. When asked whether eleting, R31 replied 13/16 at 11:02 a.m. registered R31 was independent but staff g, and that R31 was assist of off daily living. 14 p.m., trained medication (A) said that R31 goes to the lently, but wets brief once in a that staff were supposed to hours to go to the bathroom, | 2 565 | | | |

Minnesota Department of Health

STATE FORM 88V711 If continuation sheet 6 of 46

Minnesota Department of Health

| STATEME | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|--------------------------|---|-------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENI | TY CARE CENTER ON | I HUMBOLDT | BOLDT AVEN UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | incontinent episode R24's skin integrity 8/8/16, identified R3 is at risk for skin im AEB incontinence, for ADL's [assist of APPROACH: Chec PRN, provide Perior redness and breake repositioning obser hours of positioning Reposition Q 2 hou Undated nursing as reads, " 2 staff pr [total assist of two] request. Reposition up on pillows when On 11/1/16 at 3:44 care, R24 was inco when the incontinence changed. NA-Z ver bowel and bladder. On 11/2/16, from 7: was observed to be bed in a low positio a.m. NA-A started t including turn, chec incontinence brief. R24's buttocks and reddened areas an of the brief. The are time and the skin w At 10:59 a.m. a NA repositioned and che | care plan dated as edited on 24 had "PROBLEM: Resident pairments and pressure ulcers immobility, totally dependent daily livings], and mobility, k and change Q 2 hours and care after incontinence. Report down to nurse. Per turning and vation resident tolerates 2 without redness noted. It is as resident allows." It is is tant assignment sheet esent for cares Toileting: TA2 Change every 2 hours and per parting: TA2 every 2 hours Heels in bed". In p.m., during observations of not in the bed, lying on back with a nand eyes closed. At 10:44 to perform morning cares are and change of R24's belon removal of the wet brief, thighs had numerous did crevices from the wrinkling eas were blanchable at the resintact. A confirmed R24 was last necked and changed around ded, R24 was wet because | 2 565 | | | |

Minnesota Department of Health

STATE FORM 8SV711 If continuation sheet 7 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | |) DATE SURVEY COMPLETED | |
|--|---|---|--------------------------|--|----------------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| CERENIT | TY CARE CENTER ON | I HLIMBOLDT | BOLDT AVEI UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 7 | 2 565 | | | |
| | (RN)-A replied that nursing staff to follo R24 should have be and changed. SUGGESTED MET Staff education couresponsible for the | 9 a.m. the registered nurse the expectation was for all by the care plan. RN-A verified een repositioned, and checked THOD OF CORRECTION: Id be provided to all staff provision of resident care to | | | | |
| | The director of nurs | now to care for the resident. ses or designee could esident cares to ensure care plemented as written. | | | | |
| | TIME PERIOD FOF (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 570 | MN Rule 4658.0405 Plan of Care; Revis | 5 Subp. 4 Comprehensive ion | 2 570 | | | 12/16/16 |
| | care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within | resident, the resident's legal representative at least seven days of the revision of resident assessment required | | | | |
| | by: | ent is not met as evidenced on, interview, and document ailed to update the | | See above. | | |

Minnesota Department of Health

STATE FORM 8SV711 If continuation sheet 8 of 46

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--|--|-------------------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 11/0 | 0,2010 |
| CERENIT | TY CARE CENTER ON | IHUMBOLDI | BOLDT AVEI AUL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 570 | for reducing risk of (R102) reviewed for (R102) reviewed for Findings include: R102 had diagnose breath, generalized heart failure, acute pressure, anemia (Icells to carry oxyge) The care area asservealed R102 requambulating, supervunsteady when amit to standing, turning toilet, and transferrithe assessment id Event reports indicate month of Octob 10/17/16, 10/25/16, falls happened whe bathroom alone in broken finger. Proginterventions review team. R102 broke the right 4:45 a.m., when R1 bathroom and fell. It instructed R102 to right hand most of the removed for bathing of motion). On 10/13/16 at 11:3 | e plan to include interventions falls for 1 of 4 residents | | | | |
| | | 16 indicated R102 was | | | | |

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 9 of 46 8SV711

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| A. BUILDING: COMPLETE | |
|---|--------------------------|
| P WING | |
| 00538 B. WING 11/03/20 | 2016 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| CERENITY CARE CENTER ON HUMBOLDT 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | |
| | (X5) COMPLETE DATE |
| 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 | |

Minnesota Department of Health

STATE FORM 88V711 If continuation sheet 10 of 46

Minnesota Department of Health

| STATEME | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--------------------------|--|-------------------------------|--------------------------|
| | | 00538 | B. WING | | 11/0: | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENI | TY CARE CENTER ON | LHUMBOLDT | BOLDT AVEN UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE | (X5) COMPLETE DATE |
| 2 570 | and bed time, dieta repositioning, activi transfers, rehabilita items (bath, weights interventions. R102 directed staff to kee a splint at all times supervise toileting, bedside and encouremind resident to use for transfer, use belt, and to use nor The falls care plan mentioned R102 was unsteadiness when standing, moving outransferring from suplan did not mentioned R102 was related injuries throupdated the approact on 12/15/14. Approfalls to determine pakeep the call light in therapy consult, orichanges in furniture keep the environment wanderguard at all. The activities of dai plan was last edited deficits in R102's manderguard at all to the current rehability (stand pivot, limited but did not include to required supervisions). | ry information, toileting and ties of daily living, ambulation, tion programs, scheduled s, etc.), and special 's care card, dated 11/03/16, ep the resident's right hand in (remove for hygiene), keep a spill proof urinal at the rage the resident to use it, use call light, limited assist of e of pivot transfers and gait as at risk for falls due to moving from sitting to and off the toilet, and arface to surface. The care in that R102 fell five times in a finger. The long term goal, to keep R102 free from fall ugh 11/30/16. The facility last ches used to meet this goal aches listed: analyze R102's atterns, avoid restraint use, a reach, obtain a physical ent R102 when there are explacement or environment, ent clutter free, and use a times. Ity living/rehabilitation care I 11/02/16, and highlighted obility. This care plan included ation program for transfers assist of one, use gait belt), the assessment that R102 | 2 570 | | | |

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STATE FORM 6899 If continuation sheet 11 of 46 8SV711

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING: COMPLETED

> B. WING ___ 00538 11/03/2016

| | TY CARE CENTER ON HUMBOLDT 512 | нимв | ORESS, CITY, S OLDT AVEN JL, MN 551 | | |
|--------------------------|---|---|---|--|--------------------------|
| (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 11 current interventions used to reduce risk of fathe facility did not update R102's comprehens care plan after recent falls to include the follow treatment and interventions determined by clistaff and reviewed by the interdisciplinary teat 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-sk socks when appropriate, and supervise toileti. The facility policy titled, Fall Event and Post F Assessment, last updated 12/15, instructed the charge of building, clinical manager, or design to ensure the newly implemented intervention 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 plan, Registered Nurse (RN-B) said, "The fractional history of fracture should be put in the fall care plan. I will need to update that. I should I put all that in the care plan. I put it in the care card so that the staff knows, but I need to put into the care plan." SUGGESTED METHOD OF CORRECTION: resident's care plan should be revised as necessary with any changes which affect the overall provision of care to a resident to ensu the appropriate care, services and treatments provide to maximize a resident's potential for improvement. Care plans should be reviewed revised, at a minimum on a quarterly basis. A member of the care planning team could revicare plans at the time of the care conference ensure revisions are completed timely. | sive lwing linical lm: le kid ling. Fall he nee n(s) n care cture ll have t it : A | 2 570 | DELIGITING TY | |

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

| | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---|---|--|
| | 00538 | B. WING | | 11/0 | 3/2016 |
| OVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CARE CENTER ON | HIIMROLDT | BOLDT AVEN UL, MN 551 | | | |
| (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL | .D BE | (X5) COMPLETE DATE |
| Continued From pag | ge 12 | 2 570 | | | |
| ΓIME PERIOD FOR days. | R CORRECTION: Seven (7) | | | | |
| | | 2 840 | | | 12/16/16 |
| proper care. The c | riteria for determining | | | | |
| odors. A bathing placesident's plan of cacondition requires the must be given a corother day and more ncontinent resident every two hours, and | an must be part of each ure. A resident whose nat the resident remain in bed implete bath at least every often as indicated. An must be checked at least d must receive perineal care | | | | |
| Notwithstanding Mir 4658.0520, an incorphecked according written in the resider attending physician interval longer than f competent, or a fappointed conservation writing to waive production of the competent of a resident of a | nnesota Rules, part ntinent resident must be to a specific time interval nt's care plan. The resident's must authorize in writing any two hours unless the resident, unily member or legally tor, guardian, or health care who is not competent, agrees hysician involvement in erval, and this waiver is resident's care plan.] ning must be provided the bed or clothing is soiled. es the washing and drying of | | | | |
| TO NE SOB OF CHOICE IN A CABING COET | SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS REGULATORY OR LS Continued From page TIME PERIOD FOF lays. AN Rule 4658.0520 Proper Nursing Care and proper care. The condequate and proper care. The condequate and proper care. The condition requires the nust be given a condition requires the nust be given a condition requires the nust be given a condition resident every two hours, and collowing each epison (144A.04 Subd. 11 Notwithstanding Mires 1458.0520, an incondition in the resident extending physician interval longer than a competent, or a fact appointed conserval gent of a resident of a resid | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 TIME PERIOD FOR CORRECTION: Seven (7) lays. 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. The criteria for determining adequate and Proper care include: B. Clean skin and freedom from offensive adors. A bathing plan must be part of each desident'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 accontinent resident must be checked at least every two hours, and must receive perineal care collowing each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 658.0520, 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 | SAINT PAUL, MN 551 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 2 570 IME PERIOD FOR CORRECTION: Seven (7) lays. AN 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 idequate and proper care include: B. Clean skin and freedom from offensive edors. A bathing plan must be part of each esident'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 collowing each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Hotwithstanding Minnesota Rules, part 1658.0520, an incontinent resident must be thecked according to a specific time interval written in the resident's care plan. The resident's tetending physician must authorize in writing any interval longer than two hours unless the resident, competent, or a family member or legally impointed conservator, guardian, or health care ingent of a resident who is not competent, agrees in writing to waive physician involvement in letermining this interval, and this waiver is locumented in the resident's care plan.] Clean linens or clothing must be provided by the perineal care includes the washing and drying of the perineal area. Pads or diapers must be used | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 ZIME PERIOD FOR CORRECTION: Seven (7) lays. AN 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 dequate and proper care include: B. Clean skin and freedom from offensive deducts and the seven and the seven and the seven condition requires that the resident whose ondition requires that the resident remain in bed nust be given a complete bath at least every where day and more often as indicated. An acontinent resident must be checked at least every whours, and must receive perineal care collowing each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Incontinent resident with the sexident must be checked at least very two hours, and must receive perineal care collowing each episode of incontinence. [144A.04 Subd. 11. Incontinent residents with the sexident care pollowing physician must authorize in writing any interval longer than two hours unless the resident, competent, or a family member or legally propried conservator, guardian, or health care agent of a resident who is not competent, agrees a writing to waive physician involvement in letermining this interval, and this waiver is locumented in the resident's care plan.] Clean linens or clothing must be provided romptly 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 | SAINT PAUL, MN 5910/ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 Z 570 Z 57 |

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Minnesota Department of Health STATE FORM

PRINTED: 11/28/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00538 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **512 HUMBOLDT AVENUE CERENITY CARE CENTER ON HUMBOLDT** SAINT PAUL, MN 55107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 8 4 0 Continued From page 13 2 840 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 See above. 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

Minnesota Department of Health

bladder.

check and change of the incontinent pad. NA-Z verified R24 was incontinent with bowel and

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

| Minnesc | <u>ita Department of He</u> | ealth | | | | | |
|---------------|-----------------------------------|--|---------------|----------------|-------------------------------------|------------|------------------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUP | | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION | I NUMBER: | A. BUILDING: | | COMP | LETED |
| | | | | | | | |
| | | 00538 | | B. WING | | 11/03/2016 | |
| | | 00536 | | 5 | | 11/0 | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | | 512 HUME | BOLDT AVEN | IIIE | | |
| CERENI | CERENITY CARE CENTER ON HUMBOU DT | | | UL, MN 551 | | | |
| | | | | OL, WIN 331 | | | |
| (X4) ID | | TEMENT OF DEFICIEN MUST BE PRECEDED | | ID | PROVIDER'S PLAN OF CORRECTION SHOUL | | (X5) COMPLETE |
| PREFIX TAG | | SC IDENTIFYING INFO | | PREFIX TAG | CROSS-REFERENCED TO THE APPRO | | DATE |
| 1710 | | | , | 1,10 | DEFICIENCY) | | |
| | | | | | | | |
| 2 840 | Continued From pa | ige 14 | | 2 840 | | | |
| | and had a pillow on | ahdoman araa | | | | | |
| | - At 8:31 a.m. nursi | | A antorod | | | | |
| | R24's room, looked | | | | | | |
| | | | | | | | |
| | room without provid | ang cares and/or | speaking to | | | | |
| | | atil 0:00 a m D04 | waa biina an | | | | |
| | - From 8:32 a.m. ur | | | | | | |
| | back in bed with ey | | | | | | |
| | position. R24 cover | | | | | | |
| | blue blanket and ha | | | | | | |
| | - At 9:08 a.m. NA-A | | | | | | |
| | at R24, opened R24 | | | | | | |
| | stepped out of the r | | iding cares | | | | |
| | and/or speaking to | | | | | | |
| | - Between 9:12 a.m | | | | | | |
| | observed lying on b | | | | | | |
| | The bed was in low | position. R24 wa | s covered | | | | |
| | with bed spread she | eet and blue blanl | ket and had | | | | |
| | a pillow on abdome | en area. | | | | | |
| | - From 9:12 a.m. ur | ntil 9:42 a.m. no s | taff provided | | | | |
| | positioning or check | ked R24 for incon | tinence. | | | | |
| | - At 9:43 a.m. NA-A | N. walked past R24 | 4's room, | | | | |
| | looked at the room | but never entered | d. | | | | |
| | - Between 9:43 a.m | n. and 9:49 a.m. R | 24 was | | | | |
| | observed to be in b | ed, lying on back | with eyes | | | | |
| | closed. The bed wa | as in low position. | R24 was | | | | |
| | covered with a bed | | | | | | |
| | and had a pillow on | | | | | | |
| | - At 9:49 a.m. NA-A | | om. looked | | | | |
| | at R24 and stepped | | | | | | |
| | providing cares, su | | | | | | |
| | repositioning and/o | | | | | | |
| | - From 9:49 a.m. to | | | | | | |
| | observed in bed, ly | | | | | | |
| | and bed in low posi | | | | | | |
| | bed spread sheet a | | | | | | |
| | pillow on abdomen | | na naa a | | | | |
| | - At 10:41 a.m. NA- | | oom with | | | | |
| | mechanical Hoyer I | | | | | | |
| | | | | | | | |
| | morning cares which | | | | | | |
| | change of R24's inc | continence brief. t | ווסקכ | | | | |

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 15 of 46 8SV711

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|---------------------|--|-------------------|--------------------------|
| | | 00538 | B. WING _ | | 11/0 | 3/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | 11/0 | 3/2010 |
| | | 512 HIIME | BOLDT AVEN | | | |
| CERENII | TY CARE CENTER ON | SAINT PA | UL, MN 551 | 07 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 840 | Continued From pa | ge 15 | 2 840 | | | |
| | thighs had numerous crevices from the way were blanchable at NA-A confirmed R2 checked and change added, is a heavy way. The quarterly Minim 8/8/16, indicated R2 | num Data Set (MDS) dated 24 was always incontinent of | | | | |
| | | required total assistance of bbility, transfers and toileting. | | | | |
| | dated 5/12/16, read Incontinence D/T [c assistance with toile incontinent of blade | nent for Urinary incontinence ls, "[R24] triggers Urinary due to] her requiring total eting. [R24] is always der and bowel Staff will and change every 2 hours and | | | | |
| | 8/8/16, identified R2 toileting, does not u on toilet safely and every 2 hours. The required total dependent | e plan dated as edited on 24 had a self care deficit in 15 to 16 to 16 to 17 to 18 t | | | | |
| | 8/8/16, identified, "C remain intact throug APPROACH: Chec PRN, provide. Peri | care plan dated as edited on GOAL: Resident's skin will gh the next review date. k and change Q 2 hours and care after incontinence. d breakdown to nurse." | | | | |
| | reads, " 2 staff pr | esistant assignment sheet esent for cares Toileting: TA2 Change every 2 hours and per | | | | |

Minnesota Department of Health

STATE FORM 88V711 If continuation sheet 16 of 46

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|--------------------------|---|-------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENIT | Y CARE CENTER ON | A HIIMBOLD L | BOLDT AVEN UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 840 | Continued From pa | age 16 | 2 840 | | | |
| | request." | | | | | |
| | (RN)-A indicated th to follow the care p have been checked incontinence. Policy and procedu CONTINENCE ANI ASSESSMENT AN September 2010, document the resul resident's medical incontinence status a incontinence device. | 9 a.m. the registered nurse e expectation was for all staff lan and verified R24 should devery two hours for tetile URINARY DINCONTINENCE - DI | | | | |
| | director of nurses of about providing in a appropriate care are are incontinent or u staff could randoml identified as inconti- incontinent care is | • | | | | |
| | TIME PERIOD FOI days. | R CORRECTION: Seven (7) | | | | |
| 2 855 | MN Rule 4658.052 Proper Nursing Car | 0 Subp. 2 E. Adequate and re;Oral Hygiene | 2 855 | | | 12/16/16 |
| | | or determining adequate and criteria for determining er care include: | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|--|--|--|--|--|--|-------|--------------------------|
| | | 00538 | | B. WING | | 11/0 | 3/2016 |
| NAME OF PROVIDER OR SUR CERENITY CARE CENT | | | 512 HUM | DRESS, CITY, S BOLDT AVEN UL, MN 551 | | | |
| PREFIX (EACH DEF | CIENC | ATEMENT OF DEFIC Y MUST BE PRECEI .SC IDENTIFYING IN | DED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| keep the mound Measures mulips This MN Requestion of the second of the second care of th | e as reth, te st be uiremmervate control (R6; s; an R24) re. de: erved absta erved d correr (F osed e e dra er er erved e correr (F osed e e dra erved e dra erved e dra erved e dra erved e errer e erved e errer e e | needed with oral eth, or dentures used to preventent is not met is ion, interview a failed to provide 3) dependent up dependent on 11/1/16, at 3:00 nce on the lips with a heavy complain that it was 1-B was presentent to provide oral e-moistened swawers currently a cask for more stares were being observations of a.m. through 12 e lying in bed are oral care. I p.m. registered (NA)-A and NA viding care, and d no oral care in the care is a care. | as evidenced as evidenced as evidenced and document a oral care for 1 con staff for k and change 1 staff for D p.m. to have a and tongue. cating on the as bothersome. and stated the care every two abs but there and F-B verified swabs. F-B g provided f R63's care on 2:15 p.m., R63 and there were d nurse (RN)-A, -B were in the d when | 2 855 | See above. | | |

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|---------------------------|--|-------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENIT | TY CARE CENTER OF | N HUMBOLDT | BOLDT AVEN .UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 855 | Continued From pa | nge 18 | 2 855 | | | |
| | R63's quarterly Mir 3/9/16, indicated R | nimum Data Set (MDS) dated 63 had intact cognition and h activities of daily living | | | | |
| | dated, 3/20/15, rea cares. The docume Assessment (CAA) "Resident is NPO (TF (tube feeding) S cares-mouth swabs white/yellow coating treated with nystati appear to be thrush discomfort, no blee and coating is only cheeks. Per wife has started TF. Staff to cares and will refer Document review of | of the form titled, Care Plan, d, total assistance with oral ent titled, Care Area dated. 3/10/16, read, nothing per oral) and receives Staff assist with oral s Q2H (every 2 hours). Thick g over tongue, had been n but no effect-does not n. Resident denies any eding, or open areas present, on tongue-not sides of as been present since he continue to assist with oral to dental prn." of the form titled, Care Sheet, aff for mouth swabs every two | | | | |
| | dated revised Octo | of the policy titled, Mouth Care, ber 2010, directed, to review plan to assess for any special ent. | | | | |
| | | with RN-A on 11/2/16, at 1:30 cility expectation was to very two hours. | | | | |
| | director of nurses of provision of mornin providing oral cares | THOD OF CORRECTION: The or designee could observe the g cares to ensure staff are s to those residents identified aff for completion of oral care. | | | | |

Minnesota Department of Health STATE FORM

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|--------------------------|--|-------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENIT | TY CARE CENTER ON | I HUMBOLDT | BOLDT AVEN UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 855 | Continued From page 19 | | 2 855 | | | |
| | TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | | | | | |
| 2 905 | MN Rule 4658.0525 | 5 Subp. 4 Rehab - Positioning | 2 905 | | | 12/16/16 |
| | positioned in good I of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir | g. Residents must be body alignment. The position to change their own position t least every two hours, it time after the resident has the night, unless the physician at repositioning every two me period is unnecessary or rdered a different interval. | | | | |
| | by: Based on documen interview, the facility | ent is not met as evidenced It review,observation and It y failed to ensure 2 of 3 It identified at risk for It is not met as evidenced | | See above. | | |
| | Findings include: | | | | | |
| | | k of developing pressure ve a position change for 4 | | | | |
| | (CAA) dated 3/9/16 cognitively intact an R63 was assessed for pressure ulcers, load independently, repositioning every daily with cares and | f the Care Area Assessment, indicated R63 was ad able to make needs known. as being moderately at risk and directed, unable to off assist with turning and two hours, staff monitor skin I licensed staff assess every y audit. The plan of care dated | | | | |

Minnesota Department of Health

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
| | | 00538 | B. WING _ | | 11/0 | 3/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | 11/0 | 3/2010 |
| | | 512 HUME | BOLDT AVEN | | | |
| CERENI | TY CARE CENTER ON | SAINT PA | UL, MN 551 | 07 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 905 | Continued From pa | ge 20 | 2 905 | | | |
| | 9/6/16, directed at risk for pressure ulcer development and to reposition every 2 hours lying and sitting. | | | | | |
| | 11/2/16, from 7:30 a remained positione | observation of R63's care on a.m. through 10:00 a.m. R63 d to the right side while lying in r to change position. | | | | |
| | nursing assistant (National time the night shift position change for how long R63 was | on 11/2/16 at 10:00 a.m. NA)-B was not aware of what would have completed a R63. NA-B was not aware of positioned to the right side. did not have a position change | | | | |
| | was turned to the lead open area to the rigwas a white substate that NA-A and NA-E barrier the facility uscare of R63 the day not present to the right hip but at the left hip and did hip. NA-A and NA-E hip after applying baright hip. NA-A and draw sheet and a the | oom to assist with cares. R63 aft side at 10:05 a.m. and an anoth thip was observed. There note on the right hip open area as said was the protective sed. NA-A expressed taking a prior and the open area was aght hip. R63 expressed pain also was experiencing pain to not want to remain on the right arrier cream to the open area NA-B placed a chux, folded nick soaker pad under R63 ressure relieving mattress. | | | | |
| | registered nurse (R open area to the rig RN-A was not awar have last changed the find out. Currently the second statement of t | on 11/2/16, at 10:31 a.m. N)-A was not aware of the plant hip region. Furthermore, e of when the night shift would the position for R63 but would he facility did not have a dicate change of shift position | | | | |

Minnesota Department of Health

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | |) DATE SURVEY COMPLETED | |
|--|---|---|--|---|----------------------------|--------------------------|
| | | 00538 | B. WING | | 11/ | 03/2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER ON | J HUMBOLDT 512 HUM | DRESS, CITY, S Boldt Aven Lul, Mn 551(| - | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| 2 905 | time changes for reassessed at risk for R63 was administe 11/2/16, at 11:04 a. assessed the right ulcer, and measure (centimeter) width (Document review of Weekly Bath Day B10/9/16, indicated reconditions for R63. completed weekly be November to review When interviewed of verified speaking we changing R63's posterified a position of 10:00 am resulting a position change. I weekly bath audit with 10/9/16, but would require an every two verified R63 did not hours and the faciliar require an every two verified the pressure effective due to the sheet being used of mattress. R24 was at risk for repositioned every 7:57 a.m., until 10:2 minutes). | residents who have been reskin breakdown. red pain medication on m. and at 11:50 a.m. RN-A hip as a stage 2 pressure ments length 1.5 cm 0.5 cm and depth 0.2 cm. If the facility form titled, tody Audit Form, dated, no open areas or skin There were no other body audits for October or | 2 905 | | | |

Minnesota Department of Health

STATE FORM 88V711 If continuation sheet 22 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
|---|--|---------------------|--|-----------|--------------------------|
| AND I LAN OF CONTILCTION | IDENTIFICATION NOWIDET. | A. BUILDING: | | OCIVII | LLILD |
| | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF PROVIDER OR SUPPLIES | R STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENITY CARE CENTER O | N HUMBOLDT | BOLDT AVEN | | | |
| OEHEMIT OAHE OEHTER | SAINT PA | UL, MN 551 | 07 | | |
| PREFIX (EACH DEFICIENCE | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 905 Continued From p | age 22 | 2 905 | | | |
| observed: - Between 7:57 a. observed to be in closed. The bed w covered with a be and had a pillow of the covered with a pillow of the covered without providing the covered without providing the covered without providing the covered and blue blate abdomen area At 9:08 a.m. NA at the R24, opened the room without providing to R24 Between 9:12 a. observed in the bed and had a pillow of the covered with bed and the covered with | m. and 8:31 a.m. R24 was the bed, lying on back with eyes as in a low position. R24 was dispread sheet and blue blanket in abdomen area. Sing assistant (NA)-A entered at at R24 and stepped out care and/or speaking to R24. Until 9:08 a.m. R24 was in bed, eyes closed. The bed was in a was covered with bed spread anket and had a pillow on A entered R24's room, looked did and shut R24's closet and left providing cares and/or m. and 9:42 a.m. R24 was sepread sheet and blue blanket in abdomen area. Until 9:42 a.m. no staff entered on R24. A. walked past R24's room, in but never entered. m. and 9:49 a.m. R24 was bed, lying on back with eyes as in a low position. R24 was bed, lying on back with eyes as in a low position. R24 was bed, lying on back with eyes as in a low position. R24 was spread sheet and blue blanket | | | | |

Minnesota Department of Health

STATE FORM 88V711 If continuation sheet 23 of 46

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---|---|-------------------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENI | TY CARE CENTER ON | I HLIMBOLDT | BOLDT AVEN UL, MN 551 | | | |
| (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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 905 | - At 10:41 a.m. NA-mechanical Hoyer I morning cares inclu of R24's incontinen wet brief, R24's but numerous reddened wrinkling of the brief at the time and the - At 10:59 a.m. a Narepositioned aroungets dressed and is Skin assessment so "Resident has a Bratisk for pressure diplegic CP [cerebrate [range of motion] to incontinence of B/B [Peripheral vascula [history] of pressure assistance with all revery two hours] and cares, skin assesses body audit" The quarterly Minim 8/8/16, indicated R2 two staff for bed moderand R24 was at risk ulcers. R24's skin integrity 8/8/16, identified R2 and pressure ulcers dependent on staff goal was for R24's the next review date change Q 2 hours and R24 but and R24 to staff goal was for R24's the next review date change Q 2 hours and R24 but and R24 but and R24's the next review date change Q 2 hours and R24 but and R24's the next review date change Q 2 hours and R24 but and R24's the next review date change Q 2 hours and R24 but and R24's the next review date change Q 2 hours and R24's the next review date change Q 2 hours and R24 but and R24's the next review date change Q 2 hours and R24's the next review date change Q 2 hours and R24's the next review date change Q 2 hours and R24's the next review date change Q 2 hours and R24's the R24's the next review date change Q 2 hours and R24's the R24's the next review date change Q 2 hours and R24's the R24's | A entered R24's room with ift. NA-A started to perform ading turn, check and change ce brief. Upon removal of the tocks and thighs had diareas and crevices from the ff. The areas were blanchable skin was intact. A-A confirmed R24 was last diareas and stated, R24 is left in bed until now. Jummary dated 8/8/16, reads, aden scale score of 12 and is ulcers. Risk factors include: all palsy], decreased ROM all extremities, contractures, is [bowel/bladder], PVD or disease], obesity, HX is ulcers and need for mobility Staff reposition Q2H and observe skin daily with each by licensed staff with bath and Data Set (MDS) dated 24 required total assistance of obbility, transfers and toileting, as for developing pressure care plan dated as edited on 24 at risk for skin impairments and indicated R24 was totally for cares and mobility. The skin to remain intact through eximate and PRN, provide. Peri care Report redness and | 2 905 | | | |

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------------|---|-------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENIT | TY CARE CENTER ON | N HUMBOLDT | BOLDT AVEI .UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 905 | Continued From pa | ige 24 | 2 905 | | | |
| | hours of positioning | vation resident tolerates 2 g without redness noted. irs as resident allows." | | | | |
| | | ssistant assignment sheet ng: TA2 every 2 hours Heels in bed". | | | | |
| | (RN)-A explained the nursing staff to follow | 9 a.m. the registered nurse nat the expectation is for all ow the care plan and verified een repositioned every two | | | | |
| | revised May 2013, Repositioning is cri immobile or depend repositioning. Interv | tical for a resident who is dent upon staff for ventions 3. Residents who are at least an every two hour | | | | |
| | director or nurses of regarding the impor- of high pressure ris assessed, in order of pressure ulcers. could randomly obs- residents to ensure positioned with eno- | THOD OF CORRECTION: The or designee should retrain staff rtance of changing the position is resident's as frequently as to minimize the development. A member of the nursing staff serve and audit repositioning or residents are being ough frequency to minimize the ping pressure ulcers. | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 965 | MN Rule 4658.0600 -Nutritional Status | 0 Subp. 2 Dietary Service | 2 965 | | | 12/16/16 |

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Minnesota Department of Health STATE FORM

PRINTED: 11/28/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING _ 00538 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **512 HUMBOLDT AVENUE CERENITY CARE CENTER ON HUMBOLDT** SAINT PAUL, MN 55107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

| 2 965 | Continued From page 25 | 2 965 | | |
|-------|---|-------|------------|--|
| | 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. | | See above. | |
| | 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. | | | |

Minnesota Department of Health

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

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------------|--|-------------------------------|--------------------------|
| | | | A. BUILDING: | | | . == |
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENI | TY CARE CENTER ON | N HUMBOLDT | BOLDT AVEI JUL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 965 | were physician ord nutritional supplem necessary, the fac R130. A nutrition assessm R130 as having a s last 60 days prior to 8/19/16. The asses high nutrition risk for receive a Mighty Sh A registered dieticial indicated the RD weight loss over the verbalized a dislike made her sick; and change in nutritional versus Mighty Shake A RD note dated 9/ a 10 pound weight | lers for R130 to receive a ent three times a day, when ility had not provided this to ment dated 8/22/16, noted significant weight loss in the padmission, which was sment indicated R130 was at or weight loss and was to make nutritional supplement. An (RD) note dated 9/7/16, was alerted to 10.4 pound a past 20 days; the resident for meals served as they the resident requested a all supplement to Ensure | 2 965 | | | |
| | 3 of 17 refusals; an complaining of nau A RD note 9/16/16, daily probiotic yogu stools and weight lo A RD note dated 9/returned from the h pneumonia and that was much better ar On 10/7/16, the physician ordered the administered three | | | | | |

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PRINTED: 11/28/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00538 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **512 HUMBOLDT AVENUE CERENITY CARE CENTER ON HUMBOLDT** SAINT PAUL, MN 55107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 6 5 Continued From page 27 2 9 6 5 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

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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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|--------------------------|---|-------------------|--------------------------|
| | | | A. BUILDING. | | | |
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| CERENIT | TY CARE CENTER ON | I HUMBOLDT | BOLDT AVEI UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 965 | Continued From pa | ge 28 | 2 965 | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 21325 | MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser | | 21325 | | | 12/16/16 |
| | home must provide resource, routine de needs of each reside include dental exant fillings and crowns, oral surgery, bridge orthodontic procede that are provided for | e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the , as limited by third party icies. | | | | |
| | by: Based on observative review, the facility frecommendations of the second se | ent is not met as evidenced ion, interview and document ailed to ensure dentist were implemented for 1 of 3 h identified dental needs. | | See above. | | |
| | Findings include: | | | | | |
| | have missing teeth | 9 p.m. R75 was observed to . A review of R75's record resident had been seen by a sion on 1/22/15. | | | | |
| | (HUC)-G reviewed had been to the del dentist had recomn months later. HUC- not able to find any | 9 p.m. health unit coordinator R75's record and found R75 ntist on 3/31/15, and the nended a return visit six G stated at this time they were other dentist visit in R75's wed the surveyor a dental | | | | |

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Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------------|--|------|-------------------------------|--|
| | | | A. BUILDING: | | | | |
| | | 00538 | B. WING | ····· | 11/0 | 3/2016 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | | |
| CERENIT | TY CARE CENTER ON | N HUMBOLDT | BOLDT AVEI NUL, MN 551 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| 21325 | the dental visit and dental service the far HUC-G stated they consent for the faci. On 11/03/16, 10:23 information services had a new dental vithe dentist's 3/31/15 director of HIS state and a new dental consent of the facility's 11/30/Services revealed requality dental services and as needed. SUGGESTED MET director or nurses of resident consent for family member or rewhether or not dent Consents should be | R75 on 1/23/15. HUC-G stated consent form were from a acility stopped using in 5/15. were not able to find a dental lity's current dental provider. a.m., the director of health s (HIS) stated R75 had not isit scheduled to follow up on 5 recommendations. The ed R75 had "slipped through" onsent had not been obtained. 10, revised policy titled Dental residents were to receive ces upon admission, yearly THOD OF CORRECTION: The predefined could review all rems to ensure the resident, ep-payee has indicated tal services are requested. e obtained for those residents | | | | | |
| | scheduled as need | rvices and dental appointments ed. A member of the nursing ould randomly review resident compliance. | | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | | |
| 21375 | MN Rule 4658.0800 Program | 0 Subp. 1 Infection Control; | 21375 | | | 12/16/16 | |
| | home must establis | on control program. A nursing sh and maintain an infection signed to provide a safe and | | | | | |

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| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|--|-------|-------------------------------|--|
| | | 00538 | B. WING | | 11/0 | 3/2016 | |
| | PROVIDER OR SUPPLIER | N HUMBOLDT 512 HUM | DDRESS, CITY, BOLDT AVE | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | |
| 21375 | sanitary environme | nt. | 21375 | | | | |
| | by: Based on observat review, facility failed prevent the spread glucose monitoring R56, R63, R54) ob monitoring; for han 3 residents (R57, F of daily living; and f | ent is not met as evidenced ion, interview, and document d to implement procedures to of infection during blood for 4 of 4 residents (R10, served for blood glucose dwashing during cares for 3 of 863 R54) reviewed for activities or 2 of 7 residents (R96, R62) edication administration. | | See above. | | | |
| | monitoring observal was observed to we remove a basket of supplies from the number of the hall to R10's roundoor, walked into Fapplied gloves. RN supply basket on to test strip into gluco finger and obtained gloves into garbage basket on top of me sharp pointed medicontainer, tossed reglucometer basket medication cart. RN hand sanitizer. RN sanitize glucometer. | 1 a.m. when asked RN-G | | | | | |
| | indicated the same | glucometer was used on ired blood glucose readings | | | | | |

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| STATEME | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|----------------------------------|--|---|--------------------------|--|-------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENITY CARE CENTER ON HUMBOLDT | | | BOLDT AVEN UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21375 | and confirmed it hat RN-G stated the glis sanitized between of walked into nurse's Clorox hydrogen per wipes. Container without non-bleach statement then indicated to satisfy obtain one cloth, conclean for 10 to 30 s. On 11/3/16, at 10:2 glucometer check find glucometer with a precipitation of the glucometer of t | d not been sanitized after use. ucometer was supposed to be each resident. RN-G then station to obtain green top eroxide container of sanitizing as observed to have ent printed on the front. RN-G anitize glucometer she would over the glucometer and wipe it econds. O a.m. after doing a or R56, RN-E wiped the product titled Clorox Hydrogen ckly wiping the glucometer ucometer in a container and er in the medication cart. When cility's glucometer cleansing tated not knowing and looked container. RN-E read the and stated it was to remain . O a.m. the administrator Hydrogen Peroxide was a | 21375 | | | |

Minnesota Department of Health

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Minnesota Department of Health

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|----------------------------------|-----------------------|---|---------------|---|-----------|------------------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | | | | | |
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| | | | | TATE TIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| CERENITY CARE CENTER ON HUMBOLDT | | BOLDT AVE | | | | |
| SAINT PA | | UL, MN 551 | 07 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | | COMPLETE DATE |
| 1710 | | , | 171.0 | DEFICIENCY) | | |
| 01075 | Canting and Every no | 00 | 21375 | | | 1 |
| 21375 | Continued From pa | ge 32 | 213/5 | | | |
| | disinfection. 8. Rem | nove gloves. 9. Apply hand | | | | |
| | sanitizer or wash ha | ands." | | | | |
| | | | | | | |
| | | omprehensive Service & | | | | |
| | | leaning and Disinfecting your | | | | |
| | | ood Glucose Meter dated May | | | | |
| | | tion 1 Cleaning and | | | | |
| | commercially availa | completed by using a | | | | |
| | | ent or germicide wipe. Many | | | | |
| | | cleaner and disinfectant. If | | | | |
| | | ent on the meter, two wipes | | | | |
| | , . | wipe to clean and a second | | | | |
| | | Step 2 Remove wipe from | | | | |
| | | er. Follow instructions on | | | | |
| | package. If wipe is | very wet, gently wring wipe to | | | | |
| | | id. Step 3 Wipe down meter | | | | |
| | | sides. DO NOT WRAP THE | | | | |
| | | . Take extreme care not to get | | | | |
| | | p and key code ports of the | | | | |
| | meter. Step 4 Let m | | | | | |
| | | ructions. Dispose of wipe | | | | |
| | | nd that blood glucose meters and disinfected after each | | | | |
| | | etation that individually | | | | |
| | | eed to be cleaned and | | | | |
| | O | ecting can be accomplished | | | | |
| | | red disinfectant detergent or | | | | |
| | | proved for healthcare | | | | |
| | | rtant than an LTC facility | | | | |
| | | n for infection control The | | | | |
| | | lude addressing the cleaning | | | | |
| | | olood glucose meters." | | | | |
| | | G | | | | |
| | | of R57's morning cares on | | | | |
| | | n. nursing assistant (NA)-F | | | | |
| | | m, turned on water, washed | | | | |
| | | ds, wiped hands, turned off | | | | |
| | | loves. NA-F asked R57 what | | | | |
| | she wanted to wear | today and removed clothes | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|---|---|--|--------------------------|--|-------------------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | |
| CERENI | TY CARE CENTER ON | IHUMBOLDI | BOLDT AVEN UL, MN 551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21375 | Continued From pa | ge 33 | 21375 | | | |
| | from closet. NA-F looked for cleansing wipes, was unable to find any, removed gloves, tossed in garbage and left room. | | | | | |
| | applied clean glove indicated it was not protectors, informed dressed, then wash NA-F applied R57's rolled R57 toward vamount bowel mov garbage and applie R57's pant legs up toward resident. NA elevated head of be walker seat and pur R57, put transfer be into bed, strapped be lowered bed and satransferred R57 to and removed transbathroom, flushed in hands for 10 seconclean gloves, walker R57's nightgown, and eyeglasses. NA-F the dirty linens. NA-F was R57's dentures. R5 NA-F removed glove knocked on door, end dentures in R57's in linens and held bag room. About five feremoved her gloves wheeling R57 down | a.m. NA-F walked into room, s, checked R57's pad and wet. NA-F applied R57's leg d R57 she would get her led R57's face with wash cloth. It is socks, pants, removed pad, window, wiped away small ement, tossed pad into d clean pad. NA-F pulled and pulled wheelchair over la-F assisted R57 to sit up, led, removed R57's shoes from them on R57. NA-F sat up left on, transferred R57 back belt, laid R57 back down, at R57 up again. NA-F sitting position in wheelchair fer belt. NA-F walked into collet, removed gloves, washed ds, wiped hands, applied led back into room, removed pplied shirt, sweater and wisted shut garbage bag with ralked into bathroom to clean 7 asked for a drink of water. Les and left room. NA-F intered room and gave R57 a paplied clean gloves and put nouth. NA-F picked up bagged as NA-F wheeled R57 from let down the hall NA-F sand held them while in the hall. NA-F tossed linen utility room and washed hands for 10 seconds. | | | | |

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Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

00538

NAME OF PROVIDER OR SUPPLIER

CERENITY CARE CENTER ON HUMBOLDT

Minnesota Department of Health

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:
B. WING
B. WING
TIT ODDE

STREET ADDRESS, CITY, STATE, ZIP CODE

SAINT PAUL, MN 55107

| 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 | | | | | |
| 21375 | Continued From page 34 | 21375 | | | | | | | |
| | 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 | | | | | | | | |

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| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|---------------------|--|-------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 3/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CERENI | CERENITY CARE CENTER ON HUMBOLDT 512 HUM SAINT PA | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 21375 | 11/2/16, at 9:55 a.n came to the room, wash hands, turned put hands under the seconds, NA-A turn hands, dried hands donned a pair of gloroom at the same t use hand sanitizer gloves. | n. nursing assistant (NA)-A went into the bathroom to d on the water with bare hands, e water stream, after 2 led off the water with bare with a paper towel and loves. NA-B came into the lime and did not wash hands or before donning a pair of | 21375 | | | |
| | movement which N cleanse away the b provide perineal cle handing back and f barrier cream wear further contamination barrier cream which bedside drawer with NA-B removed the not wash or sanitize another pair of glow NA-A was observed. | At of a large loose bowel A-A and NA-B used wipes to owel movement and to eansing. NA-A and NA-B were orth a tube of protective ing contaminated gloves, and the tube of protective at then was put back into R63's mout being sanitized. NA-A and contaminated gloves but did the hands before donning these. After completing cares, at to wash hands for 5 seconds. It is a large loose bowel. | | | | |
| | thought the handware hands for 30 second On 11/2/16, at 10:1 assistant (TMA-A) blood glucose mon wash or sanitize har gloves. TMA-A obtained the gloves washing or sanitizing sanitize the glucome. | on 11/2/16, at 10:13 a.m. NA-A ashing policy was to wash ds or while singing the ABC's. 4 a.m. trained medication came into the room to do a itor for R63. TMA-A did not nds and donned a pair of ained the sample of blood, and left the room without ng hands. TMA-A did not eter and took the glucometer er wing. TMA-B sanitized the | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|-------------------------------|--|-------------------------------|--------------------------|
| | | 00538 | B. WING | | 11/0 | 03/2016 |
| | PROVIDER OR SUPPLIER | J HUMBOLDT 512 HUM | DDRESS, CITY, S BOLDT AVEN | | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| 21375 | glucometer using a bin. TMA-B wiped the with the sanitizing with the blood was gloves and proceed and running water finterviewed at 10:26 facility handwashing while singing happy cart, TMA-B proced and wiped off the gleft the glucometer medication cart. On 11/2/16, at 3:55 medication administ antipsychotic medic (milligrams) into the and then into the minds were then adwashing hands RN-cart and began sett RN-D punched out medication metoprotheir hand and placemed cup. The medication pass and touched. | wipe from a purple topped he glucometer for 15 seconds | 21375 | | | |
| | | led: Use an alcohol-based | | | | |

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STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE | SURVEY LETED | |
|--------------------------|---|--|--------------------------|--|-----------|--------------------------|--|
| 7.110 1 27.11 | or connection | BENTH TOX THOMBET. | A. BUILDING: | | 001111 | | |
| | | 00538 | B. WING | | 11/0 | 3/2016 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| CERENIT | TY CARE CENTER ON | IHUMBOLDI | BOLDT AVEN UL, MN 551 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE | |
| 21375 | Continued From pa | ge 37 | 21375 | | | | |
| | hand rub cdntaining alternatively, soap (non-antimicrobial) a situations c. Before medications;." | g at least 62% alcohol; or, (antimicrobial or and water for the following ore preparing or handling | | | | | |
| | director of nurses (review and revise the cleansing/disinfection Staff could then be and a member of the observe staff during also be educated the | THOD OF CORRECTION: The DON) or designee should he facility's policy on the ng of multi-use glucometers. educated on the revised policy he nursing staff could randomly g glucometer use. Staff should he appropriateness of g medication administrations. | | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | | |
| 21426 | MN St. Statute 144 Prevention And Cor | A.04 Subd. 3 Tuberculosis ntrol | 21426 | | | 12/16/16 | |
| | maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implements | e provider must establish and nensive tuberculosis ogram according to the most is infection control guidelines d States Centers for Disease ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines. | | | | | |
| | (b) Written complia be maintained by the | ance with this subdivision must ne nursing home. | | | | | |

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| Minnesota Department of Health | | | | | | | |
|--|--|--|---|--|---|--------------------------|--|
| STATEMENT OF DEFICIE AND PLAN OF CORRECT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
| | | 00538 | B. WING | | 11/03/2016 | | |
| NAME OF PROVIDER OF | R SUPPLIER | | DRESS, CITY, | STATE, ZIP CODE | 1 170 | | |
| OFFICIAL OARE O | | 512 HUMI | BOLDT AVE | NUE | | | |
| CERENITY CARE CENTER ON HUMBOLDT SAINT P. | | SAINT PA | UL, MN 551 | 07 | | | |
| PREFIX (EACH | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE | |
| 21426 Continued | d From pa | ge 38 | 21426 | | | | |
| by: Based on failed to of tuberculo of 5 resid failed to of given for TB screet evaluation reviewed Findings R52 was R52's adr R52's imr given the millimeter second si negative of the second si negative of S1's start record record record record record record record record record si negative of second si exists and record | interview locument sis (TB) sents (R52 locument 2 of 5 empling; and a results for TB scribble admitted finites admitted finites step is (mm) a rep TST with a date was realed E1 6, with 0 rep TST with a locument of the p | and document review, facility complete results of the kin (TST) that was given for 1) reviewed for TB screening; complete results of the TST ployees (E1, E3) reviewed for failed to document medical or 2 of 5 employees (E4, E5) reening. To the facility on 9/6/16, per inimum Data Set (MDS). The record revealed R52 was TST on 6/9/16, with 0 and negative results. The reas given on 6/26/16, with at did not indicate mm read. 8/10/16. E1's immunization was given the first step TST mm and negative results. The reas not given. 8/8/16. E3's immunization was given the first step TST mm and negative results. The reas given on 9/28/16, but was 7/27/16. E4's immunization | | MN St. Statute 144.04 Subd.3 Tuberculosis Prevention and Cont A Nursing Home provider must es and maintain a comprehensive Tuberculosis Infection Control Pro according to the most current tube infection control guidelines. The Policy and Procedure titled Fa Tuberculosis Screening-Administr and Interpretation of Tuberculin SI has been reviewed and deemed appropriate. The policy and procedure titled Fa Tuberculosis, Employee Screening been reviewed and updated to inc Health Care Workers with newly in TST or IGRA require a medical ev to rule out a diagnosis of active Te disease prior to any direct residen contact. R52 has had a second step TST. E4 and E5 both received medical evaluations. Mandatory education for all license nursing staff will be provided on D 6th and 7th, 2016. Education will in | tablish gram erculosis acility ation kin Tests acility g has lude dentified raluation 3 t | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|---|---|--------------------------|
| | | 00538 | B. WING | | 11/03/2 | 2016 |
| | PROVIDER OR SUPPLIER TY CARE CENTER ON | N HUMBOLDT 512 HUME | DRESS, CITY, BOLDT AVE | _ | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE C | (X5) COMPLETE DATE |
| 21426 | record revealed E4 8/8/16, with 18mm received a chest x-results. E4 did not not received a chest x-results. E4 did not not receive a record revealed E5 TB-gold test results chest x-ray 9/22/16 not receive a medic On 11/3/16, at 11:5 completed with ass (ADON) who confir ADON stated she of for TB immunization facility had interpretevaluation different 4, which directs face (HCW) with newly ithe HCW has direct should be documer evaluation to rule of disease. Facility Tuberculosi and Interpretation of dated August 2013 must be read in minimust be read in minimust be considered free not address the need following negative of symptoms of the properties of the properties of symptoms of the properties of t | was given the second TST on and positive results. E4 ray on 8/10/16, with negative receive a medical evaluation. 9/21/16. E5's immunization 's 9/21/16, Quantiferon is were positive. E5 received a r | 21426 | the review of the policies Facility Tuberculosis Screening- Administ and Interpretation of Tuberculin S and Facility Tuberculosis, Employ Screening. Audits will be completed to assure current residents have had a two- and that results are reflected in m Audits will be completed through 24, 2017 on all new admissions to the two step process reflects resu reflected in mm read. New employee audits will be comp through January 24, 2017 to verify need for medical evaluations have completed prior to any direct residentate. All audits will be reported to the Q Council in January and the Quality shall determine if ongoing audit so is required. The Infection Control Coordinator/designee is responsite monitoring compliance. Date of Completion: December 16 | kin Tests ee e all step TST m read. January o assure lts are pleted y any e been dent uality y Council chedule | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | | |
|---|--|---|---------------------|--|-------|--------------------------|--|--|
| | | 00538 | B. WING | | 11/0 | 3/2016 | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, S | STATE, ZIP CODE | | | | |
| CERENI | CERENITY CARE CENTER ON HUMBOLDT 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | | |
| 21426 | Continued From pa | ge 40 | 21426 | | | | | |
| | Tuberculosis screet ensure the policy w | es on resident and employee ning and perform audits to as being followed. R CORRECTION: Twenty-one | | | | | | |
| 21545 | MN Rule 4658.1320 | A.B.C Medication Errors | 21545 | | | 12/16/16 | | |
| | percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long-incorporated by refe purposes of this part (1) a discrepar prescribed and what administered to rese (2) the administered to redications. B. It is free of a derror. A significant (1) an error of discomfort or jeopal safety; or (2) medication error requires the medication error coprecipitate a reoccut toxicity. All medication error report must be that occurs. Any signesident reactions in the state of the section of the | st ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident rdizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single uld alter that level and urrence of symptoms or ions are administered as ident report or medication e filed for any medication error guificant medication errors or nust be reported to the ysician's designee and the | | | | | | |

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Minnesota Department of Health STATE FORM

PRINTED: 11/28/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00538 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **512 HUMBOLDT AVENUE CERENITY CARE CENTER ON HUMBOLDT** SAINT PAUL, MN 55107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21545 Continued From page 41 21545 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 Based on observation, interview and document See above. review, the facility failed to ensure medications were administered to 3 of 7 (R96, R82, R111) residents observed during medication administration 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:

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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

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STATEMENT OF DEFICIENCIES (X1)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | TE SURVEY MPLETED | |
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| | | 00538 | B. WING | | 11/0 | 3/2016 | |
| NAME OF F | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | |
| CERENIT | CERENITY CARE CENTER ON HUMBOLDT 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 | | | | | | |
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| 21545 | Continued From pa | ge 42 | 21545 | | | | |
| | | orders dated 11/1-11/30/16, nt was to receive two tablets | | | | | |
| | cart a bottle of Tyle tables. RN-D stated dosage, replaced the removed a bottle of stated R111 receive then placed two tab medication cup and to R111. A review of 11/1-11/30/16, reversibles. | removed from the medication nol Extra Strength 500 mg d R111 did not receive that ne bottle in the cart and f Tylenol 325 mg tablets. RN-D ed the 325 mg dose. RN-D elets of Tylenol 325 mg into the d administered the medication of the physician orders dated aled the resident was to mg, two tablets for a total of | | | | | |
| | | revised policy titled cations, indicated medications stered in accordance with | | | | | |
| | director of nurses (retrain the staff per medication erros. T consulting pharmac | THOD OF CORRECTION: The DON) or designee should son who had committed the the DON or designee or cist could observe random staff ons were administered without | | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | | |
| 21620 | MN Rule 4658.134 | 5 Labeling of Drugs | 21620 | | | 12/16/16 | |
| | Drugs used in the r in accordance with | nursing home must be labeled part 6800.6300. | | | | | |

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interview on 11/03/16 at 2:19 p.m., the director of nursing (DON) confirmed that all inhalers should

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

have a pharmacy label.

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| STATEMENT OF DEFICIENCIES (X* AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | | E SURVEY PLETED |
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| 21620 | from the foil storage lacked a pharmacy When asked about 11/02/16 at 10:59 a assistant (TMA-C) sunlabeled Advair avan interview on 11/0 practical nurse (LPI Advair needed to ha 11/03/16 at 2:19 p.r. Advair Diskus need days after opening. The document titled Diskus directed use month after you ren R7 had a current phinsulin on a sliding 11/02/16 revealed the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in There was not much indicating that the number of the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the second floor we lacked a date that in the secon | e pouch. The inhaler also | | | | |

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STATEMENT OF DEFICIENCIES (X1)

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