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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EV73

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

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

* Code: **A, 8*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Thomas Linhoff, DSFM — 03/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/23/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/16/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245255
March 15, 2016

Mr. Michael Syltie, Administrator
Cerenity Care Center on Humboldt
512 Humboldt Avenue
Saint Paul, Minnesota 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 February 4, 2016 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 F 458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

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

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 15, 2016

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

RE: Project Number S5255025

Dear Mr. Syltie:

On November 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 5, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 28, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 10, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 5, 2015, and an FMS survey completed December 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 5, 2015, and the FMS survey completed December 3, 2015, effective February 4, 2016 and therefore remedies outlined in our letter to you dated November 24, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under F 458 at the time of the November 5, 2015 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245255 Y1	A. Building B. Wing Y2	12/28/2015 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0242	Correction	ID Prefix F0282	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	12/15/2015	LSC	12/15/2015	LSC	12/15/2015
ID Prefix F0309	Correction	ID Prefix F0311	Correction	ID Prefix F0314	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(c)	Completed
LSC	12/15/2015	LSC	12/15/2015	LSC	12/15/2015
ID Prefix F0315	Correction	ID Prefix F0458	Correction	ID Prefix	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.70(d)(1)(ii)	Completed	Reg. #	Completed
LSC	12/15/2015	LSC	12/15/2015	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	SR/KJ	03/15/2016	16022	12/28/2015
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/5/2015

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245255 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	3/10/2016 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0020	Correction Completed 11/09/2015	ID Prefix Reg. # NFPA 101 LSC K0033	Correction Completed 11/09/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/KJ	DATE 03/15/2016	SIGNATURE OF SURVEYOR 12424	DATE 03/10/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/5/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245255 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/10/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0014	02/04/2016	LSC K0018	02/04/2016	LSC K0020	02/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	02/04/2016	LSC K0029	02/04/2016	LSC K0033	02/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	02/04/2016	LSC K0046	02/04/2016	LSC K0048	02/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	02/04/2016	LSC K0052	02/04/2016	LSC K0054	02/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0056	02/04/2016	LSC K0062	02/04/2016	LSC K0067	02/04/2016

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/KJ	03/15/2016	12424	03/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245255 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/10/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction				
Reg. # NFPA 101	Completed				
LSC K0074	02/04/2016				

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/KJ	03/15/2016	12424	03/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/3/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EV73

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

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/05/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B***, 8 (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 12/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/14/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Health Waiver F458 request sent to CMS 12/16/2015
Posted 12/16/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 24, 2015

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

RE: Project Number S5255025

Dear Mr. Syltie:

On November 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the

attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 15, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 15, 2015 the following remedy will be imposed:

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

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.

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 February 5, 2016 (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 May 5, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive self administration medication assessment was completed to determine safe medication administration for 1 of 1 resident (R47) observed to receive medication through a nebulizer (breathing treatment) during the survey. On 11/2/15 at 7:00 p.m., registered nurse (RN)-E entered R47's room and set up medication in a nebulizer machine. RN-E attached the nebulizer via a mask and left the room. At 7:24 p.m., R 47 was sitting in her room with the mask on her face	F 176	F176 Nursing Management staff has completed self-administration observations within the electronic health record on all current residents, including R47, with nebulizer orders. All residents deemed appropriate to self-administer nebulizer treatments have been reviewed in IDT and have received physician orders self-administer nebulizer treatments. Nebulizer orders indicate in special instructions if nebulizer is able to be self-administered.	12/15/15

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

Electronically Signed | 12/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 and the nebulizer machine still on. Interview at 7:25 p.m. with RN-E, indicated that R 47's nebulizer takes about 7 minutes to do, and R47 will leave the machine on until the medication is gone, and sometimes R 47 will remove the nebulizer when it is done, RN-E indicated she did not know if R47 had a self administration assessment or an order to self administer medications. Review of R47's record on 11/2/15 at 7:30 p.m., identified a physician order for Ipratropium-albuterol (medicine that enlarges airways in the lungs) solution for nebulization four times a day, with the order received on 4/23/15, however, R47's record lacked an assessment for self administration of medication or physician order for self administration of medication. Interview with RN-A on 11/4/15 at 7:45 a.m., indicated the self administration of medication assessment could be found under observations in the record. Review of R47's record on 11/4/15 at 8:00 a.m. indicated the assessment was completed on 11/3/15 at 9:28 a.m., a day after R47's medication administration observation and interview with RN-E. A physicians order was also received on 11/3/15 for R47 to self administer the nebulizer. Review of policy and procedure labeled "Self Administration of Medication,"indicated the following: 1. Using the Self Administration Observation, residents will be given the choice to self-administer their medications upon admission. 2. If the resident desires to SAM any of their meds, the observation will be completed to assess if the resident physically and cognitively	F 176	Facility developed new process specific to self-administration of medications. Self-administration of medications observation will be completed upon admission for all residents, then annually/quarterly and PRN as indicated. If resident is deemed able to self-administer medications an order will be obtained from physician, placed in resident□s electronic chart and added to resident□s Care Plan. Mandatory in-servicing conducted for all nursing personnel, to ensure understanding of self-administration of medications procedure for each resident. This in-servicing includes verbal and written components; post-test completed to confirm employee comprehension of education provided. This will ensure all residents have a self-administration observation completed timely and physician orders are obtained to self-administer medications if deemed appropriate. Education to be conducted through December 14, 2015 and will be mandatory for all current nursing staff. Any new nursing staff will receive education regarding self-administration of medication process during new employee classroom orientation. To ensure compliance the Nursing Management staff or designee will conduct random audits for the next 30 days. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 2 safe to do so. 3. If it is determined that the resident is safe to SAM their meds, then the medications may be set up. This does require an additional MD order that states:Okay to SAM. 4. The nurse will indicate on the EMAR that the resident is okay to SAM their medications and what follow-up , if any, is necessary. 5. The Interdisciplinary Team will review the assessment annually, quarterly, and PRN.	F 176	approved by the Administrator. The Quality Assurance Team will implement any needed changes and determine the need for on-going monitoring/auditing after analysis.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to provide choices regarding specific times to get up and go to bed for 2 of 2 residents (R7, R73) reviewed for choices. Findings include: R7's choice to be in bed by 7:00 p.m. was not consistently honored. Document review of the assessment titled, Brief Interview and Staff assessment for Mental Status (BIMS)dated 9/15/15, indicated R7 was	F 242	F242 NAR Care Cards to be simplified and re-structured by December 15, 2015; to indicate care items across top of care card for ease of locating information. Resident identified as R7□s choice of bedtime was reviewed with her and remains her preference. R73□s choice of rising was reviewed with her and remains her preference. To ensure that all resident choices are being honored per facility policy, specific resident preferences regarding wake time and bed time will be	12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 3 cognitively intact. R7's plan of care for choices dated 3/11/15, read, Resident frequently requests to go to bed after dinner (approx [sic] 6:30 p.m.) The undated nursing assistant care sheet read, "Resident to bed each night 6:30-6:50 p.m.. Resident wishes to be alone in her room between 7:00 p.m.-8:30 every evening to meditate." During an observation on 11/2/15, at 6:45 p.m. R7 was partially undressed and sitting in the wheel chair positioned next to the bed waiting for the nursing assistant (NA)-D to return to finish evening cares. When interviewed on 11/2/15, at 6:45 p.m. R7 stated that she was extremely frustrated because it was not unusual for the nursing assistants to start her cares and then get called to go and help someone else. R7 explained that the staff knew that she had anxiety and that this caused her anxiety level to elevate. At 7:05 p.m. NA-D returned to assist R7 with evening cares and go to bed. R7 expressed to NA-D she was very frustrated that NA-D did not remain with her until cares were completed. NA-D explained that she was called to help someone else. At 7:20 p.m. registered nurse RN-D was interviewed regarding pulling the nursing assistant away from R7 and RN-D said she did not but would check with NA-E, who may have pulled NA-D to assist with someone else. On 11/3/15, at 11:30 a.m., during interview, R7 said it was not unusual for NA-E to pull staff that was helping R7, during the middle of cares. R7 explained that she had requested to be settled in bed at 7:00 p.m. so that she can pray and said this was very important to her. R7 stated that this had been reported to management in the past	F 242	indicated on NAR Care Card for all residents. Mandatory in-servicing conducted for all nursing personnel, to ensure understanding of new NAR Care Card structure, importance of reading care card before start of shift, following care card, honoring resident time requests and notification to resident if requested times would need to be altered, importance of completing resident cares once started. Education to be conducted through December 14, 2015 and will be mandatory for all current nursing staff. Any new nursing staff will receive education regarding items listed above during new employee classroom orientation. Members of the IDT team have developed a resident preferences questionnaire that will be used for random audits regarding honoring resident preferences. Random weekly audits will be conducted by IDT members or designee over the next 60 days to ascertain the facility is meeting specific resident preferences regarding their health care and to identify staff needing additional or ongoing education. Analysis of the questionnaire results and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement any needed changes and determine the need for on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 4	F 242		

and that her bedtime continues to be inconsistent. R7 stated that it happens far too often that her help is called away during bedtime cares and expressed that this caused R7 frustration and anxiety.

Document review of notes dated 5/18/15, from the licensed clinical social worker (LICSW) read, Problem, anxiety/worry As evidenced by :Problem-focused thinking, rumination, worry, racing and obsessive thoughts. Goal: Reduce overall frequency, intensity and duration of anxiety so that daily functioning is unimpaired.

R73's choice to be up in the morning by 7:30 a.m. was not consistently honored.

R73's plan of care for ADL (activities of daily living) Functional/ Rehabilitation Potential dated 8/6/15, indicated, total to extensive assist with ADL's. Ensure resident is out of bed by 7:30 a.m. every morning."

Document review of the assessment titled, Brief Interview and Staff assessment for Mental Status (BIMS) dated 10/20/15, indicated R73 was cognitively intact.

During an observation on 11/4/15, at 7:30 a.m. R73 was lying in bed and expressed hoping to get up soon. R73 explained that her choice was to get up by 7:30 a.m. but cannot get up without help. R73 indicated if the staff cannot get her up by 7:30 a.m. they should let her know why, because being awake in bed and waiting to get up after 7:30 is "stressful" and causes her to feel "anxious."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 5 Nursing assistant (NA)-C came to the room at 8:00 a.m. to help R73 get up for the day. When questioned what time the care assignment sheet identifed R73 was to get up, NA-C explained that she was new to the unit and had not checked the assignment sheet. During an interview on 11/5/15, at 2:00 p.m. RN-A validated R7 had a specific time identified to be in bed at night and R73 had a specific time identified to be up in the morning. RN-A indicated that staff should honor the requests and if staff are unable to honor the requests it was expected that the residents be informed that the time would need to be altered and an explanation given of why this was necessary.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review, interview and observation, the facility failed to ensure care plan interventions were followed for 1 of 1 resident (R73) in the sample who was at risk for pressure ulcers and required assistance with toileting. Findings include: R73's plan of care for Pressure Ulcer dated 7/30/15, directed staff, "Per turning and	F 282	F282 R73□s Care Plan reviewed and remains current. NAR Care Cards to be simplified and re-structured by December 15, 2015; to indicate care items across top of care card for ease of locating information. By which time, Clinical IDT members will have reviewed and ensured accuracy of all resident Care Plans, in accordance with physician orders.	12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 repositioning observation, resident can tolerate over two hours of offloading without redness. Will reposition as indicated." During continuous observation on 11/4/15, at 8:10 a.m., R73 was wheeled in the wheel chair to the dining room/activity room where she remained without an offer to offload or change position until 1:50 p.m. At 1:50 p.m., licensed practical nurse (LPN)-B took R73 to the bedroom for a dressing change to the left ankle. R73 expressed to LPN-B she hoped she would be assisted to stand and walk soon since there had been no offers for a position change since getting up this morning. At 2:10 p.m., NA-C took R73 into the bathroom and stood to transfer to the toilet. R73's posterior thighs and buttocks were red with deep craters and crevices from skin wrinkling and incontinence. When interviewed during care, NA-C verified no offers to offload or change position were made for R73 until 2:10 p.m. When interviewed on 11/5/15, at 2:00 p.m., registered nurse (RN)-A verified the aide assignment sheet and the resident plan of care are to be followed. RN-A explained that according to the resident assessment for a resident who is at risk for developing pressure ulcers requires a minimum of every two to three hours to have offloading and/or position change. R73's plan of care for Urinary Incontinence dated 7/30/15, read," Is currently frequently incontinent of bladder and bowel. Extensive assist with toileting. Provide incontinence care after each incontinent episode."	F 282	Mandatory in-servicing conducted for all nursing personnel, to ensure understanding of new NAR Care Card structure, importance of reading care card before start of shift, following care card, honoring resident time requests and notification to resident if requested times would need to be altered, importance of completing resident cares once started. Education to be conducted through December 14, 2015 and will be mandatory for all current nursing staff. Any new nursing staff will receive education regarding items listed above during new employee classroom orientation. To ensure compliance, Clinical Manager or designee will audit all resident Care Cards weekly at minimum, indefinitely and adjustments will be made as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 During continuous observation on 11/4/15, at 8:10 a.m., R73 was toileted during morning cares by nursing assistant (NA)-C. R73's Incontinence brief was saturated with urine. R73 was wheeled in the wheel chair to the dining room/activity room where she remained without an offer to check for incontinence, or prompt to attempt toileting until 1:50 p.m., when licensed practical nurse (LPN)-B took R73 to the bedroom for a dressing change to the left ankle. R73 expressed to LPN-B she hoped she would be toileted soon, since no offers had been made since getting up this morning. At 2:10 p.m. NA-C took R73 into the bathroom and the incontinence brief was saturated with urine. R73 stood to transfer to the toilet and the posterior thighs and buttocks were red with deep craters and crevices from skin wrinkling and incontinence. When interviewed during care, NA-C verified no offers to check, change or toilet were made for R73 until 2:10 p.m. When interviewed on 11/5/15, at 2:00 p.m. registered nurse (RN)-A verified the aide assignment sheet and the resident plan of care were to be followed, and according to the resident assessment for a resident who is incontinent, the resident needs to be checked at least every two to three hours.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure visits by the hospice provider were coordinated with the facility to promote communication and appropriate care for 1 of 1 resident (R56) reviewed for hospice. Findings include: During an interview on 11/4/15, at 10:16 a.m., the health unit coordinator (HUC) and licensed practical nurse (LPN)-A responsible for R56's cares, did not know when or what time hospice would be in to care for R56, or where to look up the information, but they would call hospice and ask. Both verified the information was not available and did not know which day of the week hospice staff came to provide services to R56. A review of a separate hospice chart for R56 revealed a calendar for September 2015 showing that 3 times a week an aide visits at varying days of the week. There was no October or November schedule of visits available for the nurse or aide. The HUC said she would call hospice to obtain the time schedule for the aide and nurse visits. The facility plan of care dated 8/17/15, directed staff: Resident is at end of life r/t (related to) terminal diagnosis of Alzheimer's. The goal was, To keep resident comfortable during end of life care, and ensure continuity of care and family support with collaboration between hospice organization and Cerenity Humboldt. The approach was to follow Hospice care plan. The	F 309	F309 Facility has created a Hospice Binder for each unit; which will include a current hospice care plan and hospice services schedule calendar for any resident that is receiving Hospice services. Any other Hospice documentation will be located in the resident□s electronic medical record. Care Plans and NAR care cards for any residents with Hospice Services will indicate Hospice Services, refer to Hospice Binder for detailed information on services and visits. Mandatory in-servicing conducted for all impacted personnel, to ensure understanding of new process for residents with Hospice services and where to locate Hospice Services information. Annual Hospice training will be conducted for all impacted personnel thereafter. Facility to conduct in-servicing with each Hospice Provider regarding new Hospice Binders on each unit at facility and facility requirements for Hospice to communicate with facility nursing personnel: any changes Hospice makes to their care plan or services, provide a copy of the most current Hospice care plan including Hospice NAR services and provide a Hospice services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 plan of care did not indicate what days of the week or what times hospice would be providing services. The undated nursing assistant care sheet directed staff R56 received "Hospice" but there was no further information to coordinate care. During an interview on 11/4/15, at 10:16 a.m. the HUC, and at 10:22 a.m., LPN-A did not know where the separate care plan for hospice services was located. Interviews with nursing assistant (NA)-A, NA-B, NA-F on 11/4/15, at 10:30 a.m. confirmed they were not aware of the specific hospice routine for R56. The NAs did not know what services the hospice aide provided for R56, did not know the time scheduled for hospice services, and did not know where to find the information. Document review of the hospice form titled, Hospice Certification and Plan of Care, Certification period 8/17/15 through 11/14/15, read, Aide 3 wk [sic] 13 wk [sic] and directed Elimination: catheter care cleanse around meatus, empty if full and report to facility nurse. Hygiene: Other: Cleanse and dry hands well, May roll up washcloth and put into hand grasp. Activity: Transfer to bed/chair with assistance: Use Hoyer lift, use two to transfer. Hygiene: Oral care assist pt with brushing teeth and apply lip moisturizer. Hygiene: Shave assist with shaving face with razor or electric. Activity: Assist with positioning, repositioning alignment position pt with pillows in bed and chair for comfort. Pt. leans to right side. Hygiene: Skin care apply lotion to arms and legs and feet. Report any open areas to RN, CM and facility nurse. Hygiene: bath bed. Elimination: incontinent care cleanse peri area	F 309	schedule calendar which includes dates and times of Hospice services. To ensure compliance, the Quality Management Coordinator or designee will conduct random audits indefinitely. Analysis of the audits and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 after each incontinent episode, Report to RN any open areas or redness. Hygiene: nail care may clean fingernails but do not trim due to diabetes. Hygiene: Bath Shower. Safety: universal precautions. When interviewed on 11/4/15, at 10:30 a.m., NA-B who works full time, verified was not aware that the hospice aide was scheduled three times a week, and was not aware of what cares were performed as addressed on the hospice plan of care. NA-B verified the cares could be scheduled better if the facility staff knew what times hospice would be in to care for R56. When interviewed on 11/5/15, at 1:27 p.m., RN-C was not sure when hospice came to the facility and said there was not specific communication with the aides about hospice visits. RN-C verified the system for the coordination of care would be better if there was a schedule to follow from hospice that could be communicated with the facility staff.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and consistently implement ambulation services to improve and/or maintain residents' ambulation abilities for 3 of 3 residents (R4, R64, R73) in the	F 311	F311 Residents identified as: R4, R64, & R73, ambulation programs reviewed and adjustments made as indicated. NAR Care Cards to be simplified and	12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 11 sample reviewed for restorative nursing services. Findings include: R4's care plan, last revised 6/19/15, directed staff, "REHAB AMBULATION PROGRAM: 50-70 ft w/FWW BID [feet with four wheel walker twice daily], use transfer belt, limited assist 1. *Resident requires some time to process, let her know 5 min [minutes] before ambulation that she is going for a walk." Review of physical therapy progress note and discharge summary, dated 6/19/15 and rehab nursing program for ambulation, dated 6/18/15, directed the initiation of a rehab nursing program to maintain ambulation progress made during physical therapy. Nursing staff were directed to provide R4 limited assistance to walk for 50 to 70 feet twice daily with a transfer belt and four wheeled walker. R4's minimum data set (MDS), dated 8/10/15, indicated R4 was cognitively intact. On 11/2/15 at 7:13 p.m., R4 reported she would like to walk and exercise more, which she was not currently being offered or assisted with as often as she would prefer. Review of October and November 2015 Point of Care for the item set "How did the resident walk in corridor?" revealed "Activity did not occur" on 10/31, 10/29, 10/28, 10/27, 10/18, 10/15, 10/13, 10/09, 10/8, 10/4, 10/3, 10/2, 10/1. R4 was noted as walking only once on 10/26, 10/24, 10/23, 10/22, 10/19, 10/17, 10/14, 10/12, 10/10, 10/7, and 10/6. On the Restorative Flow Sheet, dated	F 311	re-structured by December 15, 2015; to indicate care items across top of care card for ease of locating information. By which time, all other residents with Rehab ambulation programs will be reviewed and adjustments made as indicated. Facility has discontinued NAR paper Rehab Program flow sheets and created a Rehab Programs Binder which will be located on each unit. Rehab Programs Binder will include any Nursing Rehab Programs provided by the Therapy department for residents on that unit and a form for NAR to document only if resident has special requests, refuses to ambulate or has trouble with ambulation program. Each resident with an ambulation program will be indicated on NAR Care Card and instruct NAR to refer to Rehab Programs Binder, in addition each of these residents will have a nursing order electronically sent to Point of Care for NARs. Facility designee will audit Rehab Program Binders and review any residents that have special requests, refusing to ambulate or having difficulty with ambulation programs. Items identified will be addressed, adjusted as necessary and updates reflecting this will be made to NAR care cards and resident care plans. Employee identified as (NA)-A was educated and constructive feedback given for not following facility policy and procedure regarding entry of data into resident medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 12 October and November 2015, R4 was noted as walking on 27 times out of 68 opportunities. R4 was noted as declining to walk six times, all during the 3:00 p.m. to 7:00 p.m. shift 10/3, 10/4, 10/6-10/8 and 10/11. On 11/4/15 at 2:20 p.m. the nursing assistant for R4, NA-F, reported R4 did a good job with walking, but sometimes refused. NA-F reported R4 was most likely to walk after brunch as she spent a lot of time in the bathroom in the morning. NA-F reported if R4 refused to walk she offered again and then noted a refusal. On 11/5/15 at 11:12 a.m. the nurse manager, RN-C, noted R4 had refused to walk in the past. If R4 refused, staff should re-approach and note the refusal. R64 was Interviewed 11/2/15 at 3:32 p.m. and reported she was not being assisted with ambulation as often as she would like, to gain strength. R64 reported she required assistance from staff to walk safely. R64's 9/7/15 MDS noted R64 was cognitively intact. On 11/4/15 from 8:10 a.m. R64 was noted propelling herself in her wheelchair to the elevator. R64 returned to the floor and was in dining room in her wheelchair at 10:19 a.m. R64 wheeled herself to the bedroom and got a cup of coffee at 10:37 a.m. At 10:49 a.m.,the trained medication assistant, (TMA)-B wheeled R64 to her room for medications and then R64 wheeled herself back to dining room. At 11:54 a.m. a volunteer wheeled R64 from her room to elevator. At 2:31 p.m. R64 reported she did not walk yet that day.	F 311	Mandatory in-servicing conducted for all nursing personnel, to ensure understanding of new NAR Care Card structure, importance of reading care card before start of shift, following care card, honoring resident time requests and notification to resident if requested times would need to be altered, importance of completing resident cares once started; new Rehab Programs Binder, documentation in Binder only if resident has special requests, refuses to ambulate or has trouble with ambulation program and importance of documenting with each shift worked. Education to be conducted through December 14, 2015 and will be mandatory for all current nursing staff. Any new nursing staff will receive education regarding items listed above during new employee classroom orientation. To ensure compliance, the Quality Management Coordinator, Clinical Manager or designee will conduct random audits for the next 30 days to identify needed adjustments to programs and/or staff needing additional or on-going education. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 13	F 311		

R64's care plan, last revised 9/10/15, "REHAB AMBULATION PROGRAM: 75 ft w/ [feet with] Rolling walker, supervision, follow w/ wheelchair QID [four times daily], reminding to stand tall w/ walking." No concerns with refusals were noted.

A review of the October and November Point of Care for item set "How did the resident walk in corridor?" revealed "Activity did not occur" on 11/1, 10/30, 10/10, 10/5 and 10/3. Walking in corridor was noted as occurring four or three times on 0 days, twice on 4 days and once on 23 days.

Review of R64's physical therapy progress and discharge summary and rehab nursing program for ambulation, dated 9/1/15, directed the initiation of an ambulation program to improve strength and mobility. The plan included nursing staff providing supervision for R64 to walk 75 feet four times daily with a rolling walker. Staff were directed to follow with a wheelchair for safety.

The October and November 2015 Restorative Flowsheet revealed a nursing assistant, (NA)-A walked R64 twice during day from October 1-22, with the exception of walking only once on 10/16 and twice a day from 10/26 to 10/31. However, a review of NA-A's payroll data revealed NA-A did not work on 10/31, 10/30, 10/16 to 10/18, 10/2 to 10/4, and 10/10. R64 was noted as walking on the evening shift 21 out of 66 opportunities and declined to walk 4 times.

On 11/5/15 at 11:13 a.m. RN-C reported she was not aware of any refusals to walk from R64. RN-C stated that NA-A should not mark she walked R64 on days she did not work. RN-C explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 14 that R64 should have been walked four times a day and verified R64 missed several opportunities to walk on the evening shift. RN-C monitored ambulation programs quarterly and with significant changes. On 11/5/15 at 1:49 p.m. NA-A noted she typically walked R64 twice during her shift. However, she did not walk R64 on days she did not work. NA-A noted she was behind in her documentation and was trying to catch up during the morning of 11/5. NA-A noted she accidentally marked she walked R64 on days she did not work. The Ambulation Policy, dated 2/2011, directed staff "Procedure: 1. Check resident's medical record for ambulation order; note equipment ordered if any. 2. Check care plan for specific instructions. 3. Explain the procedure to the resident. 4. Be sure the resident is properly dressed with proper footwear (shoes tied, if wearing). Use ambulation belt per facility policy and resident's orders. 5. Grasp the gait belt (if ordered) with one hand and support the resident as needed with the other hand. Do not let go of the gait belt. 6. Walk with the resident with your gait matching the residents gait." and "General Documentation Guidelines: Date, time (or shift), as appropriate; Residents level of function; Refusal of treatment; Type of assistance required; Any complications, if present." R73's plan of care for Rehabilitation Potential read, "REHAB NURSING PROGRAM FOR AMBULATION:Resident is to ambulate 150 feet bid (twice a day) with limited assistance, rolling walker and gait belt."	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 15 During continuous observation on 11/4/15, at 8:10 a.m. R73 was wheeled in the wheel chair to the dining room/activity room where she remained without an offer to ambulate. At 1:50 p.m., licensed practical nurse (LPN)-B took R73 to the bedroom for a dressing change to the left ankle. R73 expressed to LPN-B she hoped she would be stood and walked soon since there had been no offers for a position change since getting up this morning. Nursing assistant NA-C came to the room at 2:10 pm to provide cares to R73 and verified ambulation had not been offered between getting R73 up at 8:10 a.m. and this time. When interviewed on 11/3/15, at 9:43 a.m. R73 expressed concern about not getting walked as much as she would like especially on the weekends. R73 said there would be a rare exception when she may decline to walk, if she is expecting a phone call, or if visitors are here, but R73 said she expected the staff to set up a plan for fitting in the ambulation at another time and not just indicate she declined. Document review of the October 2015 form titled, Restorative Flowsheet, to ambulate 150 feet bid with limited assistance rolling walker and gait belt, revealed no ambulation occurred at all on October 1,19, and 31st. The day shift missed ambulation on October 2,14, and 30th. The evening shift missed ambulation on October 3, 4, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 27, 28, and 29th. R73 ambulated in the month of October 2015 thirty-nine times out of a possible sixty two opportunities for restorative ambulation. When interviewed on 11/5/15 at 2:15 p.m. RN-A verified R73 should be ambulated according to the restorative assessment and the staff needed	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 16 to schedule consistent times at the beginning of the day and evening shift with R73.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident identified at risk for pressure ulcers (PU), received timely repositioning for 1 of 3 residents (R73) in the sample. Findings include: R73 did not receive a position change or off loading for six hours from 8:10 a.m. until 2:10 p.m. Document review of the assessment titled, Brief Interview and Staff assessment for Mental Status (BIMS) dated 10/20/15, indicated R73 was cognitively intact. Document review of the Care Area Assessment (CAA) dated 10/6/15, titled, Pressure Ulcers, read, "Pressure ulcer to L. Achillis,[sic] present on	F 314	F314 Resident identified as R73□s turning and reposition observation reviewed and adjustments made as indicated. NAR Care Cards to be simplified and re-structured by December 15, 2015; to indicate care items across top of care card for ease of locating information. By which time all like residents will be reviewed and adjustments will be made as indicated. DON and IDT members have reviewed current wound program. Clinical Manager is now Wound Care Certified and will oversee and review ongoing facility pressure ulcer prevention program. Mandatory in-servicing conducted for all nursing personnel, to ensure	12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17 admission, and requiring extensive assist with transfers and bed mobility. A score of 16 indicates she is at risk. Per turning and repositioning observation, resident can tolerate over 2 hours of offloading without redness." The undated nursing assistant care sheet directed, reposition assist of 1. R73's plan of care for Pressure Ulcer dated 7/30/15, read, "Per turning and repositioning observation, resident can tolerate over two hours of offloading without redness. Will reposition as indicated." When interviewed on 11/3/15, at 9:43 a.m., R73 expressed concern about staff not assisting her with position changes as much as she would like and explained that it was important that her position be changed. During continuous observation on 11/4/15, at 8:10 a.m., R73 was wheeled in the wheel chair to the dining room/activity room where she remained without an offer to offload or change position. At 1:50 p.m. licensed practical nurse (LPN)-B took R73 to the bedroom for a dressing change to the left ankle. R73 expressed to LPN-B she hoped she would be assisted with a position change since there had been no offers since getting up this morning. When interviewed on 11/4/15 at 2:00 p.m., LPN-B explained that there should have been an offer to offload and change position at least every two to three hours throughout the shift. LPN-B said she would get the nursing assistant to assist R73. At 2:10 p.m., NA-C took R73 into the bathroom and stood to transfer her to the toilet. R73's	F 314	understanding of new NAR Care Card structure, importance of reading care card before start of shift, following care card, honoring resident time requests and notification to resident if requested times would need to be altered, importance of completing resident cares once started. Education to be conducted through December 14, 2015 and will be mandatory for all current nursing staff. Any new nursing staff will receive education regarding items listed above during new employee classroom orientation. To ensure compliance, the Staff Development Coordinator (SDC) or designee will conduct random observational audits for the next 30 days to identify staff needing additional or ongoing education. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18 posterior thighs and buttocks were red with deep craters and crevices from skin wrinkling and incontinence. When interviewed during care, NA-C verified no offers to offload or change position were made for R73 until 2:10 p.m. When interviewed on 11/5/15, at 2:00 p.m., registered nurse (RN)-A verified the aide assignment sheet and the resident plan of care are to be followed. RN-A explained that according to the resident assessment for a resident who is at risk for developing pressure ulcers requires a minimum of every two to three hours to have offloading and/or position change.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident identified as incontinent of urine, received the necessary care and services to manage incontinence for 1 of 1 residents (R73) in the sample.	F 315	F315 Resident identified as R73 Care Plan reviewed and remains current. NAR Care Cards to be simplified and re-structured by December 15, 2015; to indicate care items across top of care card for ease of locating information. By which time all	12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 19 Findings include: During continuous observation on 11/4/15, at 8:10 a.m., R73 was toileted during morning cares by nursing assistant (NA)-C. R73's Incontinence brief was saturated with urine. R73 was wheeled in the wheel chair to the dining room/activity room where she remained without an offer to check for incontinence, or prompt to attempt toileting. At 1:50 p.m., licensed practical nurse (LPN)-B brought R73 to the bedroom for a dressing change to the left ankle. R73 expressed to LPN-B she hoped she would be toileted soon, since no offers had been made since getting up this morning. Document review of the Care Area Assessment (CAA) dated 10/6/15, titled, Urinary Incontinence, read, "requiring extensive assist with toileting does not feel when she needs to go until she has had an incontinent episode. Staff will continue to prompt to toilet every hour and PRN (whenever necessary)." The undated nursing assistant care sheet directed staff of R73's urinary incontinence, identified she was frequently incontinent of bladder and directed staff that R73 required extensive assist with toileting and to provide incontinence care after each incontinent episode. R73's plan of care for Urinary Incontinence dated 7/30/15, read," Is currently frequently incontinent of bladder and bowel. Extensive assist with toileting. Provide incontinence care after each incontinent episode." Document review of the assessment titled, Brief Interview and Staff assessment for Mental Status (BIMS) dated 10/20/15, indicated R73 was	F 315	other resident Care Plans will be reviewed and adjusted as indicated. Mandatory in-servicing conducted for all nursing personnel, to ensure understanding of new NAR Care Card structure, importance of reading care card before start of shift, following care card, honoring resident time requests and notification to resident if requested times would need to be altered, importance of completing resident cares once started. Education to be conducted through December 14, 2015 and will be mandatory for all current nursing staff. Any new nursing staff will receive education regarding items listed above during new employee classroom orientation. To ensure compliance, the Staff Development Coordinator (SDC) or designee will conduct random observational audits for the next 30 days to identify staff needing additional or ongoing education. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 20 cognitively intact. When interviewed on 11/3/15, at 9:43 a.m. R73 expressed concern that, especially on the weekends, "The staff do not fit in toileting as much as I would like." R73 stated that on rare occasions, if R73 was expecting a phone call she would refuse to be toileted or checked but explained that it would be important to her if staff would set up a plan, instead of saying she refused. R73 explained not being aware of being incontinent or not. When interviewed on 11/4/15 at 2:00 p.m., LPN-B indicated there should have been an offer to check for incontinence and toilet at least every two hours throughout the shift. LPN-B said she would have the nursing assistant assist R73. At 2:10 p.m. NA-C took R73 into the bathroom and the incontinence brief was saturated with urine. R73 stood to transfer to the toilet and the posterior thighs and buttocks were red with deep craters and crevices from skin wrinkling and incontinence. When interviewed during care, NA-C verified no offers to check, change or toilet were made for R73 until 2:10 p.m. When interviewed on 11/5/15, at 2:00 p.m. registered nurse (RN)-A verified the aide assignment sheet and the resident plan of care were to be followed, and according to the resident assessment for a resident who is incontinent, the resident needs to be checked at least every two to three hours.	F 315		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	F 458		12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 458	Continued From page 21 Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms for four double resident rooms 222, 223, 226 and 326 affecting eight residents. Findings include: Resident double occupancy square footage was observed to be approximately 155 square feet instead of the required 160 square feet for double occupancy in rooms 222, 223, 226 and 326. When interviewed on 11/2/15, at 12:30 p.m. the administrator acknowledged a waiver was in place, allowing double occupancy in the 155 square foot double rooms versus the regulation of 160 square feet in double occupancy rooms. Resident's residing in those rooms did not offer complaints regarding the size of their rooms.	F 458	F458 Variance on file	

Cerenity
SENIOR CARE
Humboldt

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

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

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

November 5, 2015

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 221, 222, 223, 226, and 326 be approved for double occupancy. The rooms are approximately 155 square feet of useable floor area rather than the required 160 square feet. These rooms were originally two-bed resident rooms, and have been approved to be so from a waiver since July 2001.

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

Sincerely,

Michael Syltie
Administrator/ CEO
Cerenity Care Center- Humboldt

Received via email 12/7/15. SER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cerenity Care Center on Humboldt was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/04/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cerenity Care Center Humboldt is a 4-story building with a no basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction.. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is partially fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors,resident rooms, closets and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 117 beds and had a census of 113 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain vertical opening protection as required by NFPA 101 - 2000 edition, section 19.3.1.1. This deficiency could affect 10 residents on each floor within the smoke compartment. Findings include: On facility tour between 09:00 AM and 02:00 PM on 11/05/2015, it was observed that the 2nd, 3rd and 4th floor soiled linen chute across from room 242. did not automatically close and positive latch when tested. This deficiency was verified by the facility Director of Environmental Services.	K 020	Linen chutes in the utility rooms on second, third, and fourth floor now self-close and latch. The chutes were repaired on November 9, 2015. Linen chutes doors will be added to the monthly PM schedule for monitoring.	11/9/15
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1	K 033		11/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect all 117 residents. Findings include: On facility tour between 09:00 AM and 02:00 PM on 11/05/2015, it was observed that: Stairwell enclosures are not protected with at least a 1 hour fire protection in the following areas: 1) 4th floor South stairwell by room 428 had a penetration in the corridor wall around electrical conduit. 2) 4th floor East stairwell by room 408 had a penetration in the corridor wall around a fire sprinkler pipe. 3) 4th floor center stairwell had a portion of concrete block missing in the corridor wall.	K 033	1. 4th Floor- South stairwell by room 428 around electrical conduit has been caulked with fire rated approved caulk. Completed on November 9, 2015. 2. 4th Floor- East stairwell by room 408 around sprinkler pipe has been caulked with fire rated approved caulk. Completed on November 9, 2015. 3. 4th Floor- Center stairwell concrete was repaired on November 9, 2015. Inspections will be conducted for penetration to smoke barrier wall before contractors leave property. This will be monitored by the Director of Environmental Services, Lisa Pierce.	