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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EWNF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00354

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/22/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Mandatory DPNA, effective 11/21/14, is discontinued, effective 10/23/14.

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NE II 10/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/24/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 23, 2014

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

RE: Project Number S5365023

Dear Ms. Juday Barnett:

On October 20, 2014, we informed you that the following enforcement remedy was being imposed:

> • Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 21, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 20, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 21, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on August 21, 2014, and lack of verification of substantial compliance with the health deficiencies at the time of our October 20, 2014 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 22, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 21, 2014, as of October 17, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of October 20, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 21, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 21, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 21, 2014, is to be rescinded.

In our letter of October 20, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 21, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 17, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5365

Electronically Delivered: October 23, 2014

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

Dear Ms. Juday Barnett:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 17, 2014 the above facility is certified for for:

90 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 20, 2014

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

RE: Project Number S5365023

Dear Ms. Juday Barnett:

On September 4, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 21, 2014. 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.

Compliance with the health deficiencies issued pursuant to the August 21, 2014 standard survey has not yet been verified. As noted above, the most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 21, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 21, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 21, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been

subject to a denial of payment. Therefore, Cerenity Care Center - Marian is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 21, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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 February 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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.

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245365	A. Building B. Wing	10/22/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **10/17/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/17/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **10/17/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **10/17/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **10/17/2014**	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	Date:	Signature of Surveyor:	Date:
	SR/AK	10/23/2014	03023	10/22/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/21/2014

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00354	A. Building B. Wing	10/22/2014

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **10/17/2014**	ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **10/17/2014**	ID Prefix **21100** Reg. # **MN Rule 4658.0650 Subp.** LSC	Correction Completed **10/17/2014**
ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **10/17/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **10/17/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Su** LSC	Correction Completed **10/17/2014**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	10/23/2014	03023	10/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/21/2014

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: EWNF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00354

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

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

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

4. TYPE OF ACTION: **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 **08/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Candace Bolduc, HFE NE II 09/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/19/2014 (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
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4691

September 4, 2014

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

RE: Project Number S5365023

Dear Ms. Juday Barnett:

On August 21, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 30, 2014, 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 September 30, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 21, 2014 (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 February 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 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	Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		10/17/14

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

Electronically Signed | 09/16/2014

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
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F 225	Continued From page 1 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 225	Cerenity Senior Care - Marian of Saint	

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F 225	Continued From page 2 facility failed to immediately report and thoroughly investigate an allegation of potential mistreatment for 1 of 3 residents (R77) reviewed for abuse prohibition. Findings Include: R77 was interviewed on 8/19/14, at 1:43 p.m., and reported how a nursing assistant (NA)-C yelled at him while he was taking a shower several months ago. R77 explained he thought NA-C wanted him to cross his arms and when that was wrong, NA-C yelled at him again, indicating to do something else. R77 stated he was not hard of hearing and didn't think NA-C needed to yell at him. R77 was unsure whether he had told anyone, but stated other staff persons had heard the yelling. He recalled that the clinical manager/licensed practical nurse (LPN)-B had spoken with him the next day and asked if he wanted NA-C to care for him again, and R77 said he did not. R77 stated NA-C had not cared for him since the incident. Review of the last quarterly Minimum Data Set (MDS), dated 5/16/14, identified R77 was cognitively intact with a BIMS (brief interview for mental status) assessment score of 15, had no behaviors, needed extensive assist from staff for transfers, dressing and weight bearing support. LPN-B was interviewed on 8/20/14, at 10:50 a.m. regarding the incident with R77. LPN-B recalled that it had happened several months ago. LPN-B explained that R77 had told the evening staff nurse about the incident and the evening nurse had left a message for LPN-B, the clinical manager, to talk with R77 the next morning. LPN-B verified having interviewed R77 regarding the incident the next morning and added that other staff had also been interviewed. LPN-B confirmed NA-C did not work with R77 again and that shortly afterwards, R77 had moved to	F 225	Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible Allegation of Complaince. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to particopate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non- compliance or admission by the Facility. It is the policy of Cerenity Senior Care-Marian of Saint Paul to thoroughly investigate any and all allegations of mistreatment and report according to	

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F 225	Continued From page 3 another floor. LPN-B also stated NA-C had a loud voice and that the concern had been addressed. LPN-B verified there was no documentation from her regarding the message left by the evening nurse, the interview with R77 or with other staff. When LPN-B was asked who else was aware of the incident, she stated the social services staff for the unit had also been notified at the time of the incident. On 8/20/14, at 11:20 a.m., the unit's social worker (SW) was interviewed and did not recall having information regarding the described incident. Review of R77's medical record lacked any documentation regarding the incident between NA-C and R77 from the reporting staff nurse or from LPN-B. A review of NA-C's personal record included an "Employee-Supervisor Conference Form" dated 6/24/14. The form indicated NA-C had received a verbal warning and addressed several areas. Facts: "per resident [R77] interview, NAR (nursing assistant registered) [NA-C] yelled at him when he didn't understand what she was asking." Objectives: "Treat everyone with respect. Resident's treated with dignity and compassion." Solutions: "Will attend annual skills fair, customer service training." And Action: "Disciplinary action will proceed to next level if behavior continues." The form was signed by LPN-B on 6/24/14. The alleged employee [NA-C] refused to sign the form and wrote: "I don't agree with this because the residents don't understand what I am saying to them." The employee conference form was provided to survey staff by the administrator on 8/21/14, at 10:50 a.m. The administrator stated, "this is related to the incident resident [R77] reported." The director of nursing (DON) and the director of	F 225	facility policy dated 5/10/14 which was provided the surveyors at the time of the survey and according to federal law. At the time the incident was reported by R77 an investigation occurred and abuse was immediately ruled out. R77 stated he did not want a change in caregiver and he re-stated that she spoke loudly but did not " yell" at him. When the surveyors arrived and re-ivinterviewed R77 we did file the incident to appropriate agency based on surveyor interpretation of the report. The Minnesota Department of Health Office of Health Facility Complaints deteremined that no further action was necessary . Corrective action will be achieved by re-educating all staff on the facility Abuse Prevention Plan. The facility will continue to report all allegations of mistreatment to the Director of Social Service, Director of Nursing and the Administrator. The facility IDT (Interdisplinary Team) reviews all resident incidents in the morning report meeting as well to assure thorough follow up. The facility will conduct thorough investigations of all allegations of mistreatment. The Director of Social Service is responsible for evaluating the effectiveness of this plan . The outcome of this plan will be reviewed at the next Quarterly Quality Assurance Council Meeting and ongoing as needed.	

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F 225	Continued From page 4	F 225		

social services (DSS) were interviewed on 8/20/14, at 1:00 p.m. When informed of the incident between R77 and NA-C, the DON stated the incident should have been reported and investigated immediately, but denied having been previously informed of the incident. The DON then called LPN-B, the clinical manager, for additional details. LPN-B informed the DON of the incident between NA-C and R77 which included information regarding staff personality, not getting along, and a verification that R77 had not been harmed.

The facility's Abuse Prevention Plan Policy last revised on 10/11, identified Abuse as: "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. On page 4 under Investigation of Incidents and Allegations, bullet a. read: "All accidents, incidents as well as allegations of abuse or neglect will be investigated by the Director of Social Services, Director of Nursing or Designee." On page 5 under the heading; "Reporting of Suspected Resident Abuse, Neglect and or Crime" the information included: "Staff will notify the facility Charge of Building immediately of any report of possible abuse or neglect. The Charge of Building (COB) will immediately notify the Administrator, Director of Nursing and Director of Social Services or designee."
In the procedure, "Vulnerable adult Reporting and Investigation" last revised 10/11, bullet 1.) included: "Staff will notify the Administrator, Director of Nursing (DON) and Director of Social Services (DSS) immediately upon witnessing or receiving a report of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. If the DON

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F 225	Continued From page 5 or DSS are unavailable or it is an evening, weekend, or holiday the report will be made to the Charge of Building who will in turn contact the DON or DSS. The COB will follow the Vulnerable Adult Action Plans."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse Prevention Plan Policy to immediately notify the administrator, director of nursing (DON), the director of social services (DSS), and failed to conduct a thorough investigation of an allegation of mistreatment for 1 of 3 residents (R77) reviewed for abuse prohibition. Findings Include: The facility's Abuse Prevention Plan Policy last revised on 10/11, identified Abuse as: "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." On page 4 under the heading, Investigation of Incidents and Allegations, bullet A. included: "All accidents, incidents as well as allegations of abuse or neglect will be investigated by the Director of Social Services, Director of Nursing or Designee."	F 226	It is the policy of Cerenity Senior Care-Marian of Saint Paul to thoroughly investigate any and all allegations of mistreatment and report according to facility policy dated 5/10/14 which was provided the surveyors at the time of the survey and according to federal law. At the time the incident was reported by R77 an investigation occurred and abuse was immediately ruled out. R77 stated he did not want a change in caregiver and he re-stated that she spoke loudly but did not " yell" at him. When the surveyors arrived and re-ivinterviewed R77 we did file the incident to appropriate agency based on surveyor interpretation of the report. The Minnesota Department of Health Office of Health Facility Complaints deteremined that no further action was necessary . Corrective action will be achieved by	10/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 6 On page 5 under the heading; "Reporting of Suspected Resident Abuse, Neglect and or Crime" the information included: "Staff will notify the facility Charge of Building immediately of any report of possible abuse or neglect. The Charge of Building (COB) will immediately notify the Administrator, Director of Nursing and Director of Social Services or designee." The facility's procedure "Vulnerable adult Reporting and Investigation" last revised 10/11, Bullet 1 included: "Staff will notify the Administrator, Director of Nursing (DON) and Director of Social Services (DSS) immediately upon witnessing or receiving a report of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. If the DON or DSS are unavailable or it is an evening, weekend, or holiday the report will be made to the Charge of Building who will in turn contact the DON or DSS. The COB will follow the Vulnerable Adult Action Plans." R77 was interviewed on 8/19/14, at 1:43 p.m., and reported how a nursing assistant (NA)-C yelled at him while he was taking a shower several months ago. R77 explained he thought NA-C wanted him to cross his arms and when that was wrong, NA-C yelled at him again, indicating to do something else. R77 stated he was not hard of hearing and didn't think NA-C needed to yell at him. R77 stated he did not like to be yelled at and added that he was unsure whether he had told anyone, but stated other staff persons had heard the yelling. He recalled that the clinical manager/licensed practical nurse (LPN)-B had spoken with him the next day and that he'd been asked if he did not want NA-C to	F 226	re-educating all staff on the facility Abuse Prevention Plan and assuring implementation of the policy. The facility will continue to report all allegations of mistreatment to the Director of Social Service, Director of Nursing and the Administrator. The facility IDT (Interdisplinary Team) reviews all resident incidents in the morning report meeting as well to assure thorough follow up. The facility will conduct thorough investigations of all allegations of mistreatment. The Director of Social Service is responsible for evaluating the effectiveness of this plan . The outcome of this plan will be reviewed at the next Quarterly Quality Assurance Council Meeting and ongoing as needed.	

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F 226	Continued From page 7	F 226		

care for him again, and he'd agreed. R77 stated NA-C had not cared for him since the incident.

R77's most recent quarterly Minimum Data Set (MDS) dated 5/16/14, identified R77 as cognitively intact with a BIMS (brief interview for mental status) assessment score of 15 (15 being the highest score indicating no cognitive impairment), experienced no behaviors, and as requiring extensive assist from staff for transfers, dressing and weight bearing support.

LPN-B was interviewed on 8/20/14, at 10:50 a.m. regarding the incident with R77. LPN-B recalled that it had happened several months ago. LPN-B explained that R77 had told the evening staff nurse about the incident and the evening nurse had left a message for LPN-B, the clinical manager, to talk with R77 the next morning. LPN-B verified having interviewed R77 regarding the incident the next morning and added that other staff had also been interviewed. LPN-B confirmed NA-C did not work with R77 again and that shortly afterwards, R77 had moved to another floor. LPN-B also stated NA-C had a loud voice and that the concern had been addressed. LPN-B verified there was no documentation from her regarding the message left by the evening nurse, the interview with R77 or with other staff. When LPN-B was asked who else was aware of the incident, she state the social services staff for the unit had also been notified at the time of the incident.

On 8/20/14, at 11:20 a.m. the unit's social worker (SW) was interviewed, she did not recall having been provided any report/information regarding the described incident.

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F 226	Continued From page 8	F 226		

Review of R77's medical record lacked any documentation regarding the incident between NA-C and R77 from the reporting staff nurse or from LPN-B.

A review of NA-C's personal record included an "Employee-Supervisor Conference Form" dated 6/24/14. The form indicated NA-C had received a verbal warning and addressed several areas. Facts: "per resident [R77] interview, NAR (nursing assistant registered) [NA-C] yelled at him when he didn't understand what she was asking." Objectives: "Treat everyone with respect. Resident's treated with dignity and compassion." Solutions: "Will attend annual skills fair, customer service training." And Action: "Disciplinary action will proceed to next level if behavior continues." The form was signed by LPN-B on 6/24/14. The alleged employee [NA-C] refused to sign the form and wrote: "I don't agree with this because the residents don't understand what I am saying to them." The employee conference form was provided to survey staff by the administrator on 8/21/14, at 10:50 a.m. The administrator stated, "this is related to the incident resident [R77] reported."

The director of nursing (DON) and the director of social services (DSS) were interviewed on 8/20/14, at 1:00 p.m. When informed of the incident, the DON stated the incident should have been reported and investigated immediately, but denied having been previously informed of the incident. The DON then called LPN-B, the clinical manager, to get additional details. LPN-B informed the DON of the details from the incident between NA-C and R77 which included information regarding staff personality, not getting along, and a verification that R77 had not been

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F 226	Continued From page 9 harmed. Although nursing staff had been aware of the incident, the NA-C had received a disciplinary verbal warning, and NA-C no longer provided care for R77, there had been no incident report filled out, and no documentation to indicate the administrator, the DON, the DSS or designee had been promptly notified of the allegation. In addition, there was no documentation at the time of the incident that revealed any type of investigation had been conducted to determine whether mistreatment had occurred with R77.	F 226		
F 241 SS=B	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, 6 of 6 residents (R109, R27, R25, R94, R105, R24) who ate in their rooms were served food in plastic dishes with plastic silverware and 1 of 4 dining rooms observed for the evening meal; residents were served dessert and salad in plastic dishes. This had the potiental to affect approximately 25 of the 80 residents in the facility. Findings include: The evening meal was observed in the second floor main dining room (DR) on 8/19/14, at 4:30 p.m. Residents who chose the cold beet salad were served the salad in plastic dishes and all of the desserts were served in plastic serving cups.	F 241	All residents will be served meals using non- disposable siverware and plates. We purchased additional tableware to support this plan. The facility policy was revised to reflect this change. All Dietary staff will be provided education regarding the policy. The Director of Culinary Services or designee will audit varied meals three times per week times two weeks, one time per week times three weeks and one time per month as needed. The Director of Culinary Services will be responsible for implementation and evaluation of the effectiveness of this	10/17/14

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F 241	Continued From page 10 At 5:15 p.m., room trays were prepared for six residents who ate in their rooms. All trays were prepared with plastic silverware in addition to the dessert and beets in plastic serving cups. 8/19/14, at 4:35 p.m. the dietary manager (DM) was interviewed and stated, "maybe we ran out of glass bowls, otherwise the food should be served in glass bowls." When interviewed on 8/19/14 at 5:20 p.m., nursing assistant (NA)-A explained that the kitchen does not send up real silverware for the room trays. "We've never been given real silverware for the room trays." NA-A indicated that maybe there wasn't enough real silverware. On 8/20/14, at 10:30 a.m., the DM was interviewed and indicated there may be a shortage of silverware and that was why plastic was used. Although no residents complained regarding use of the plastic dishes and silverware, the DM verified that plastic should not routinely be used.	F 241	plan.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not follow the individualized care plan for nail care for 1 of 1 resident (R125) reviewed for hospice. Findings include:	F 282	R125's nail care was corrected by immediately providing nail care during the survey. During the residents bath or shower the nurse will assure the residents nails are clean and trimmed.	10/17/14

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F 282	Continued From page 11 During an interview conducted with family member (FM)-B on 8/19/14, at 2:05 p.m., FM-B expressed concerns related to R125's grooming specifically related to staff not cleaning underneath the resident's fingernails. R125's current care plan dated as initiated 3/27/12, directed staff: "Nail Care on bath day by staff." During an observation on 8/20/14, at 10:37 a.m. R125 was up and dressed in a tilt/recline wheelchair. R125's fingernail tips were observed to have chipped pink nail polish. The nails were observed to be soiled underneath with blackish debris. Nursing assistant (NA)-B confirmed R125's fingernails were partially unpolished and that there was debris under the fingernails. NA-B stated that R125 had been bathed on Sunday (8/17/14) by facility staff and would be bathed again on Thursday (8/21/14) by a hospice aide. NA-B stated R125's nails were supposed to be cleaned during bath time. At 10:40 a.m. on 8/20/14, clinical manager registered nurse (RN)-A, was observed to assist two NA's to provide care for R125. RN-A looked at R125's fingernails and acknowledged they were not clean. RN-A asked NA-B to make sure R125's hands were washed. At 10:44 a.m. NA-B was observed to wheel R125 to her room to wash R125's hands, however, NA-B did not clean or attempt to clean underneath R125's nails. An interview conducted on 8/21/14, at 12:39 p.m. RN-A explained that nursing assistants from the facility and the hospice were responsible to provide nail care for R125 on her bath days which	F 282	The facility will idenity other residents in need of nail care by completing audits weekly times one month and monthly times three months and then as needed based on outcomes.	

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F 282	Continued From page 12 were Sunday and Thursday. RN-A said dependent residents' nails should be trimmed and cleaned on bath day, and should be checked with cares for any as needed cleaning.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not assure that appropriate nail care was provided for 1 of 1 resident (R125) reviewed for hospice care. Findings include: During an observation on 8/18/14, at 4:45 p.m. R125 was observed sitting up in a tilt/recline type wheelchair while waiting for dinner. At 5:04 p.m. registered nurse (RN)-B served the resident her dinner. At that time, R125's nails were observed to be long and partially painted pink on the ends of the nails. During an interview conducted with family member (FM)-B on 8/19/14, at 2:05 p.m., FM-B expressed concerns related to R125's grooming specifically related to staff not cleaning underneath the resident's fingernails. During an observation on 8/20/14, at 10:37 a.m.	F 312	R125's nail care was corrected by immediately providing nail care during the survey. During the residents bath or shower the nurse will assure the residents nails are clean and trimmed. The facility will idenity other residents in need of nail care by completing audits weekly times one month and monthly times three months and then as needed based on outcomes.	10/17/14

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F 312	Continued From page 13 R125 was up and dressed in a tilt/recline wheelchair. R125's fingernail tips were observed to have chipped pink nail polish. The nails were observed to be soiled underneath with blackish debris. Nursing assistant (NA)-B confirmed R125's fingernails were partially unpolished and that there was debris under the fingernails. NA-B stated that R125 had been bathed on Sunday (8/17/14) by facility staff and would be bathed again on Thursday (8/21/14) by a hospice aide. NA-B stated R125's nails were supposed to be cleaned during bath time. At 10:40 a.m. on 8/20/14, clinical manager RN-A, was observed to assist two NA's to provide care for R125. RN-A looked at R125's fingernails and acknowledged they were not clean. RN-A asked NA-B to make sure R125's hands were washed. At 10:44 a.m. NA-B was observed to wheel R125 to her room to wash R125's hands, however, NA-B did not clean or attempt to clean underneath R125's nails. During an interview with RN-A on 8/21/14, at 12:39 p.m. RN-A explained that nursing assistants from the facility and the hospice were responsible to provide R125's nail care on her bath days, Sunday and Thursday. RN-A stated R125's nails should be trimmed, cleaned (including underneath) on her bath days and checked with cares for any as needed cleaning. RN-A indicated R125's fingernails were trimmed yesterday, after it was brought to her attention. At 12:55 p.m. RN-A and the surveyor observed R125's fingernails again to see whether they had been cleaned adequately following that morning's bath by the hospice NA. RN-A confirmed R125's nails had not been cleaned underneath despite having a bath by the hospice aide, "today." RN-A	F 312		

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F 312	Continued From page 14	F 312		

stated, " it looks like her [R125's] nails are not being cleaned on a regular basis underneath." RN-A stated resistance should not be an issue for R125 as she had cognition issues with the dementia and if correct approach was used, R125 would cooperate with staff cleaning under her fingernails.

Annual MDS CAA dated 1/17/14, indicated "CAA not triggered but she needs total assist with all ADL's due to end stage Dementia. She is on hospice program. All needs must be anticipated. She is non-verbal except for non-sensical verbage [sic]. She does not verbally express pain but will show evedance [sic] of pain thru facial expression or pulling away."

R125's care plan dated 3/20/12, directed staff, "Severely impaired decision making ability d/t ST and LT memory impairments R/T Alzheimer's type dementia. Resident relies on staff for assistance with all daily decision making. Resistance to cares at times. Resident has difficulty following cues and directions." Interventions: "Allow resident time to process and respond to cues/directions. Potential for alteration in behavior AEB (as evidenced by) resistance to cares. Resident has rejected assistance with toileting and getting out of bed at times." Interventions: "When resident begins to resist care, STOP and try the task later. Do not force the resident to do the task."

R125's care plan dated 3/27/12, also included: "Nail Care on bath day by staff."

R125's hospice coordination in facility care plan dated 2/14/13, "Health East Hospice Home Health Aid to visit 1-2 times weekly and assist

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F 312	Continued From page 15 with ADL's (activities of daily living) as needed. Goal: Resident will be well groomed, dressed in season appropriate clothing." The facility's Policy for Care of Fingernails and Toenails undated, indicated to provide cleanliness, prevent spread of infection, and prevent injury by completing hand hygiene as appropriate. Wearing gloves when appropriate and "soak nails first in basin of warm water or do procedure following bath or shower." And "using a nail brush for cleaning under nail beds if necessary."	F 312		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F 356		10/17/14

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F 356	Continued From page 16 make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility did not ensure the posted staff nursing information included the correct census or the actual hours worked by staff discipline, per shift. Findings include: Observations on 8/18/14, at 11:30 a.m. of the staff posting was observed to identify an inaccurate census, and did not identify the actual hours worked by discipline for each shift. At 2:00 p.m. on 8/18/14, an interview was conducted with the staffing coordinator, regarding the nurse staff posting. The staffing coordinator verified the census was incorrectly listed as 79 and should have been 80. The staffing coordinator also verified shift hours were not listed or broken down into actual hours worked by staff per shift. At 2:45 p.m. the director of nursing and administrator confirmed the posting of nursing information noted on entrance to the facility failed to include the correct census or the actual hours worked by discipline for each shift.	F 356	The facility Director of Nursing and Administrator were notified upon entrance that the hours posted did not meet the latest CMS (Centers for Medicare and Nedicaid Service) interpretation. The facility immediately corrected the way the hours are posted and re-posted the hours to include actual hours worked by job class and shift. This was approved by the survey team on day one of the survey. The facility will monitor its performance in order to assure the change in practice is sustained by completing an audit of the posted nursing hours three times per week times one month and as needed thereafter. The Director of Nursing is responsible for evaluating the plan for its effectiveness. The outcome of this plan will be shared at the next Quarterly Quality Assurance Council Meeting.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		10/17/14

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F 371	Continued From page 17 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to store, prepare, and serve food in a manner to minimize the possible development of food borne illness. This had the potential to affect approximately 77 of 80 residents who received food prepared in the kitchen. Findings include: On 8/18/14, at 11:55 a.m. an initial tour of the kitchen was completed with the dietary manager (DM). The following issues were identified: The meat slicer was covered with plastic wrap and the DM stated it was ready for use. However, when the plastic was lifted, some dried food debris was noted on the blade of the meat slicer. The DM agreed the slicer blade had not been cleaned thoroughly. The large sugar and flour bins were noted to be very sticky and soiled on the lids and sides. There were approximately 20-25 small plates and saucers observed to have been put away wet and/or soiled. Fourteen dinner plates were observed to be soiled and/or wet.	F 371	The facility will procure food from sources approved or considered satifactory by federal, state and local authorities and store, prepare, distribute and serve food under sanitary conditions. All residents will be served food that is stored and prepared according to federal and state regulations to reduce the risk of foodborne illness. The Director of Culinary Services revised the specific cleaning assignments for staff and has them scheduled in acccordance with federal and state regulations. The Director of Culinary Services reviewed these changes with the dietary staff on 8/24/14 and additionally on 9/3/14. The Nutritional Supplement Policy was revised to assure expiration dates of non-self stable nutritional supplements. Dietary staff were educated on this in the meetings on 8/24/14 and 9/3/14. The proper dating and disposal of opened food was reviewed in the meetings on 8/24/14 and 9//3/14 with the dietary staff	

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F 371	Continued From page 18 A half gallon prepared ham salad was observed in the walk-in-cooler open for use, but not dated as to when it had been opened. A half of a 5 pound bag of shredded mozzarella cheese was observed to have been open for use, but was undated. During the tour, the DM acknowledged each of these issues. The DM stated she was new to the DM position in the past month and was just starting to get a sense of the areas that needed to be worked on. On 8/18/14, at 2:15 p.m., observations in the family kitchenette revealed 34 nutritional shakes were stored in the refrigerator, and had thawed to liquid form. These single serving shakes had directions on the labels indicating they were fresh for up to 14 days after being thawed. However, none of the shakes had been dated to indicate when they had been taken from the freezer and placed in the refrigerator. The dining service was observed on second floor on 8/18/14, beginning at 4:30 p.m. Six room service trays were prepared for delivery at 5:30 p.m. All of the beverages and desserts were left uncovered. The trays were transported on an open three tiered cart. When interviewed on 8/18/14 at 5:30 p.m. (NA)-A indicated trays were always delivered in that manner. On 8/20/14, at 9:00 a.m. the refrigerator in the smaller dining room (kitchenette) on second floor, 13 mighty shakes were observed to be stored thawed in the refrigerator. None of these 13 shakes had been dated to indicated when they had been thawed.	F 371	by the Director of Culinary Services. The Director of Culinary Services will assure the use of enclosed carts for transporting food. The Director of Culinary Servies and Nurse Managers will train the nursing staff on properly covering food while transporting from the kitchenettes out of the dining rooms. We added an additional drying rack for drying dishes. The rinse additive was changed to improve drying time. The dish machine temperature tracking tool will be consistently implemented. The Culinary Services Director reviewed these changes in the staff meetings on 8/24/14 and 9/3/14. The Director of Culinary Services will audit compliance with these changes daily times two weeks, three times weekly times one month , weekly times 3 months and then ongoing as needed. The Director of Culinary Services is responsible for implementing this plan and evaluating the effectiveness of this plan.	

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F 371	Continued From page 19 During an additional visit to the kitchen on 8/20/14, at 9:30 a.m., packages of cold cuts including salami, turkey, and bologna were observed to be opened for use without any indication of when they had been opened. When interviewed on 8/20/14, at 9:30 a.m. the DM stated the expectation was that foods should be dated when opened. When interviewed about the mighty shakes, the DM stated he was unaware that they required a date as to when they had been thawed. He also stated all food and beverages served as room trays were supposed to be covered during transport/delivery. The facility's policy and procedure for their Nutritional Supplement Program, revised 4/09, indicated nutritional services stocked high calorie supplements which are stored in the refrigerator to increase palatability and to ensure product safety. The policy did not address the dating of the supplements once removed from the freezer and thawed. An undated policy and procedure titled Responsibility of Nursing Service in Tray Delivery, indicated food must remain covered while being distributed through the hallways. An undated policy and procedure titled, Equipment Operations and Cleaning Procedures, indicated the dietary manager was responsible for developing cleaning procedures and all employees were responsible to follow those procedures.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		10/17/14

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F 465	Continued From page 20 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident common areas were clean and well maintained, which had the potential to impact 42 residents or their guests on the 2nd floor and failed to assure door frames were maintained in good repair for 17 residents (R102, R77, R32, R112, R178, R83, R97, R143, R84, R135, R103, R117, R71, R94, R125, R81, R98) whose doors had paint peeling off of the frames, and failed to assure that tables and chairs in common spaces on the 3rd floor were clean and in good repair for approximately 21 residents and/or their guests to use. Findings include: During the initial tour at noon on 8/18/14, several multicolored spots were noted to be contrasting from the original color of the carpet on the second and third floor. During tour with the environmental services director (ESD) on 8/21/14, at 9:30 a.m. the following observations were made: Significant sections of paint were peeling from the door frames for the following residents' rooms on the second floor long term care unit: R102, R77, R32, R112, R178, R83, R97, R143, R84, R135, R103, R117, R71, R94, R125, R81 and R98. Significant sections of paint were also noted to be	F 465	The facility plan which was communciated to the surveyors by the new Environmental Services Director at the time of the survey included making attempts to clean the carpet and if that didnt work we had scheduled a vendor to spot and extract carpet on 8/21/14. If the vendor was unable to get the carpet clean, we had already obtained two bids for carpet replacement. The vendor attempted to cellan the carpet on 8/21/14 without success. The carpet for both 2nd and 3rd floor corridors has been ordered and will be replaced as soon as vendor can obtain and install. The procedures for maintingin the carpet was revised by the Director of Environmental Services and reviewed with the janitorial staff assigned. A scheduled reventative maintenance program has also been developed to schedule routine cleaning of carpet. The furniture identified during the survey to be soiled was cleaned. Furniture that was not cleanable was removed and replaced.The procedure for cleaning the furniture was revised and was reviewed with the janitorial staff. The scheduled preventative maintenance program was revised to include routine checks of the	

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	245365	A. BUILDING _____ B. WING _____	08/21/2014

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

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F 465	Continued From page 21 peeling from the second floor family room and family dining area. Also noted on the second floor, tile was cracked near room 237. The carpet had a significant amount of soiled spots. In the second floor activity/dining room, two tables were chipped and five of fifteen chairs had dried multicolored spots on them. The ESD confirmed all findings on the second floor during tour. The ESD stated the carpet was cleaned by himself and a professional carpet cleaning company during the week. The ESD also stated the carpet may not be dried thoroughly, explaining why there were still multicolored spots contrasting from the color of the carpet. On 8/21/14, at 2:45 p.m. the spots appeared the same as they had during tour with ESD. On the 3rd floor, three of twelve chairs in the special care unit and two of ten chairs in the third floor transitional care unit had dried multicolored spots on them. Also in the third floor common area, one of two chairs near the fireplace had a tear and dried spots on it and a couch in the common area had dried black spots on it. The ESD confirmed findings throughout the tour. The undated Rotary Scrub Carpet and Carpet Shampooing and Extracting policies and procedures directed staff, "It is the policy of Marian Center to maintain clean, hygienic carpets, free of soil and debris at all times." The directions also included how to use the equipment and procedures to thoroughly clean carpet. However, the policy did not direct staff as to how frequent carpet cleaning was required.	F 465	furniture and cleaning as needed. A weekly environmental observation will be conducted by the Director of Environmental Services or designee. All items identified will be corrected. The results of the observations will be reviewed at the quarterly Quality Assurance Council Meeting. The door frames are being sanded and painted and walls identified in the family room and dining areas will be painted. A complete audit of all areas was conducted by the Director of Environmental Services and all areas identified will be corrected. The facility will continue the current work order process and also weekly observations by the Director of Environmental Services or designee will be conducted to identify areas needing attention ongoing. The cracked tiles noted have been repaired. The weekly observations by the Director of Environmental Services will identify further tile repairs needed and he will assure they are repaired. The Director of Environmental Services is responsible for evaluation of this plan. The weekly onbservations results will be reviewed at the quarterly Quality Assurance Council Meeting.	

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	245365	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

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

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cerenity Care Center Marian was found 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. Cerenity Care Center Marian is a 5-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type I(332) construction. In 1969 a 2 story addition was constructed above the 3rd story that was determined to be of type I(332) construction. In 2002 a 1 story addition was constructed to the north that was determined to be type I(332) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected, The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. Also, all sleeping rooms have single station smoke detection. The facility has a licensed capacity of 90 beds and had a census of 78 at the time of the survey. A deficiency for K-067 and annual waiver has been written in past surveys, regarding corridors	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/09/2014

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

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	245365	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

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K 000	Continued From page 1 used as a plenum. It has been determined that this facility meets the CMS S&C-06-18 letter from May 26, 2006. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4691

September 4, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5365023

Dear Ms. Juday Barnett:

The above facility was surveyed on August 18, 2014 through August 21, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00354	A. BUILDING: _____ B. WING _____	08/21/2014

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 18th, 19th, 20th, and 21st, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000		

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility did not follow the individualized care plan for nail care for 1 of 1 resident (R125) reviewed for hospice. Findings include: During an interview conducted with family member (FM)-B on 8/19/14, at 2:05 p.m., FM-B expressed concerns related to R125's grooming specifically related to staff not cleaning underneath the resident's fingernails. R125's current care plan dated as initiated 3/27/12, directed staff: "Nail Care on bath day by staff." During an observation on 8/20/14, at 10:37 a.m. R125 was up and dressed in a tilt/recline wheelchair. R125's fingernail tips were observed to have chipped pink nail polish. The nails were observed to be soiled underneath with blackish debris. Nursing assistant (NA)-B confirmed	2 565	Corrected	9/11/14

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2 565	Continued From page 2 R125's fingernails were partially unpolished and that there was debris under the fingernails. NA-B stated that R125 had been bathed on Sunday (8/17/14) by facility staff and would be bathed again on Thursday (8/21/14) by a hospice aide. NA-B stated R125's nails were supposed to be cleaned during bath time. At 10:40 a.m. on 8/20/14, clinical manager registered nurse (RN)-A, was observed to assist two NA's to provide care for R125. RN-A looked at R125's fingernails and acknowledged they were not clean. RN-A asked NA-B to make sure R125's hands were washed. At 10:44 a.m. NA-B was observed to wheel R125 to her room to wash R125's hands, however, NA-B did not clean or attempt to clean underneath R125's nails. An interview conducted on 8/21/14, at 12:39 p.m. RN-A explained that nursing assistants from the facility and the hospice were responsible to provide nail care for R125 on her bath days which were Sunday and Thursday. RN-A said dependent residents' nails should be trimmed and cleaned on bath day, and should be checked with cares for any as needed cleaning. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s) could develop and implement policies and procedures to ensure care plans are being followed for all residents; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 920	Continued From page 3	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility did not assure that appropriate nail care was provided for 1 of 1 resident (R125) reviewed for hospice care. Findings include: During an observation on 8/18/14, at 4:45 p.m. R125 was observed sitting up in a tilt/recline type wheelchair while waiting for dinner. At 5:04 p.m. registered nurse (RN)-B served the resident her dinner. At that time, R125's nails were observed to be long and partially painted pink on the ends of the nails. During an interview conducted with family member (FM)-B on 8/19/14, at 2:05 p.m., FM-B expressed concerns related to R125's grooming specifically related to staff not cleaning underneath the resident's fingernails. During an observation on 8/20/14, at 10:37 a.m. R125 was up and dressed in a tilt/recline wheelchair. R125's fingernail tips were observed to have chipped pink nail polish. The nails were observed to be soiled underneath with blackish debris. Nursing assistant (NA)-B confirmed	2 920	Corrected	9/11/14

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2 920	Continued From page 4 R125's fingernails were partially unpolished and that there was debris under the fingernails. NA-B stated that R125 had been bathed on Sunday (8/17/14) by facility staff and would be bathed again on Thursday (8/21/14) by a hospice aide. NA-B stated R125's nails were supposed to be cleaned during bath time. At 10:40 a.m. on 8/20/14, clinical manager RN-A, was observed to assist two NA's to provide care for R125. RN-A looked at R125's fingernails and acknowledged they were not clean. RN-A asked NA-B to make sure R125's hands were washed. At 10:44 a.m. NA-B was observed to wheel R125 to her room to wash R125's hands, however, NA-B did not clean or attempt to clean underneath R125's nails. During an interview with RN-A on 8/21/14, at 12:39 p.m. RN-A explained that nursing assistants from the facility and the hospice were responsible to provide R125's nail care on her bath days, Sunday and Thursday. RN-A stated R125's nails should be trimmed, cleaned (including underneath) on her bath days and checked with cares for any as needed cleaning. RN-A indicated R125's fingernails were trimmed yesterday, after it was brought to her attention. At 12:55 p.m. RN-A and the surveyor observed R125's fingernails again to see whether they had been cleaned adequately following that morning's bath by the hospice NA. RN-A confirmed R125's nails had not been cleaned underneath despite having a bath by the hospice aide, "today." RN-A stated, " it looks like her [R125's] nails are not being cleaned on a regular basis underneath." RN-A stated resistance should not be an issue for R125 as she had cognition issues with the dementia and if correct approach was used, R125 would cooperate with staff cleaning under	2 920		

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2 920	Continued From page 5 her fingernails. Annual MDS CAA dated 1/17/14, indicated "CAA not triggered but she needs total assist with all ADL's due to end stage Dementia. She is on hospice program. All needs must be anticipated. She is non-verbal except for non-sensical verbage [sic]. She does not verbally express pain but will show evedance [sic] of pain thru facial expression or pulling away." R125's care plan dated 3/20/12, directed staff, "Severely impaired decision making ability d/t ST and LT memory impairments R/T Alzheimer's type dementia. Resident relies on staff for assistance with all daily decision making. Resistance to cares at times. Resident has difficulty following cues and directions." Interventions: "Allow resident time to process and respond to cues/directions. Potential for alteration in behavior AEB (as evidenced by) resistance to cares. Resident has rejected assistance with toileting and getting out of bed at times." Interventions: "When resident begins to resist care, STOP and try the task later. Do not force the resident to do the task." R125's care plan dated 3/27/12, also included: "Nail Care on bath day by staff." R125's hospice coordination in facility care plan dated 2/14/13, "Health East Hospice Home Health Aid to visit 1-2 times weekly and assist with ADL's (activities of daily living) as needed. Goal: Resident will be well groomed, dressed in season appropriate clothing." The facility's Policy for Care of Fingernails and Toenails undated, indicated to provide cleanliness, prevent spread of infection, and	2 920		

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2 920	Continued From page 6 prevent injury by completing hand hygiene as appropriate. Wearing gloves when appropriate and "soak nails first in basin of warm water or do procedure following bath or shower." And "using a nail brush for cleaning under nail beds if necessary." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s) could develop and implement policies and procedures to ensure residents who are unable to carry out activities of daily living, to include nail care, receive the necessary services to maintain good grooming; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to store, prepare, and serve food in a manner to minimize the possible development of food borne illness. This had the potential to affect approximately 77 of 80 residents who received food prepared in the kitchen.	21100	Corrected	9/11/14

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21100	Continued From page 7 Findings include: On 8/18/14, at 11:55 a.m. an initial tour of the kitchen was completed with the dietary manager (DM). The following issues were identified: The meat slicer was covered with plastic wrap and the DM stated it was ready for use. However, when the plastic was lifted, some dried food debris was noted on the blade of the meat slicer. The DM agreed the slicer blade had not been cleaned thoroughly. The large sugar and flour bins were noted to be very sticky and soiled on the lids and sides. There were approximately 20-25 small plates and saucers observed to have been put away wet and/or soiled. Fourteen dinner plates were observed to be soiled and/or wet. A half gallon prepared ham salad was observed in the walk-in-cooler open for use, but not dated as to when it had been opened. A half of a 5 pound bag of shredded mozzarella cheese was observed to have been open for use, but was undated. During the tour, the DM acknowledged each of these issues. The DM stated she was new to the DM position in the past month and was just starting to get a sense of the areas that needed to be worked on. On 8/18/14, at 2:15 p.m., observations in the family kitchenette revealed 34 nutritional shakes were stored in the refrigerator, and had thawed to liquid form. These single serving shakes had directions on the labels indicating they were fresh for up to 14 days after being thawed. However, none of the shakes had been dated to indicate when they had been taken from the freezer and placed in the refrigerator.	21100		

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21100	Continued From page 8 The dining service was observed on second floor on 8/18/14, beginning at 4:30 p.m. Six room service trays were prepared for delivery at 5:30 p.m. All of the beverages and desserts were left uncovered. The trays were transported on an open three tiered cart. When interviewed on 8/18/14 at 5:30 p.m. (NA)-A indicated trays were always delivered in that manner. On 8/20/14, at 9:00 a.m. the refrigerator in the smaller dining room (kitchenette) on second floor, 13 mighty shakes were observed to be stored thawed in the refrigerator. None of these 13 shakes had been dated to indicated when they had been thawed. During an additional visit to the kitchen on 8/20/14, at 9:30 a.m., packages of cold cuts including salami, turkey, and bologna were observed to be opened for use without any indication of when they had been opened. When interviewed on 8/20/14, at 9:30 a.m. the DM stated the expectation was that foods should be dated when opened. When interviewed about the mighty shakes, the DM stated he was unaware that they required a date as to when they had been thawed. He also stated all food and beverages served as room trays were supposed to be covered during transport/delivery. The facility's policy and procedure for their Nutritional Supplement Program, revised 4/09, indicated nutritional services stocked high calorie supplements which are stored in the refrigerator to increase palatability and to ensure product safety. The policy did not address the dating of the supplements once removed from the freezer and thawed.	21100		

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21100	Continued From page 9 An undated policy and procedure titled Responsibility of Nursing Service in Tray Delivery, indicated food must remain covered while being distributed through the hallways. An undated policy and procedure titled, Equipment Operations and Cleaning Procedures, indicated the dietary manager was responsible for developing cleaning procedures and all employees were responsible to follow those procedures. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee (s) could develop and implement policies and procedures, train staff, assure food is stored, prepared, and served in a manner to minimize the possible development of food borne illness. Develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by:	21695		9/11/14

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21695	Continued From page 10 Based on observation, interview, and document review, the facility failed to ensure resident common areas were clean and well maintained, which had the potential to impact 42 residents or their guests on the 2nd floor and failed to assure door frames were maintained in good repair for 17 residents (R102, R77, R32, R112, R178, R83, R97, R143, R84, R135, R103, R117, R71, R94, R125, R81, R98) whose doors had paint peeling off of the frames, and failed to assure that tables and chairs in common spaces on the 3rd floor were clean and in good repair for approximately 21 residents and/or their guests to use. Findings include: During the initial tour at noon on 8/18/14, several multicolored spots were noted to be contrasting from the original color of the carpet on the second and third floor. During tour with the environmental services director (ESD) on 8/21/14, at 9:30 a.m. the following observations were made: Significant sections of paint were peeling from the door frames for the following residents' rooms on the second floor long term care unit: R102, R77, R32, R112, R178, R83, R97, R143, R84, R135, R103, R117, R71, R94, R125, R81 and R98. Significant sections of paint were also noted to be peeling from the second floor family room and family dining area. Also noted on the second floor, tile was cracked near room 237. The carpet had a significant amount of soiled spots. In the second floor activity/dining room, two tables were chipped and five of fifteen chairs had dried multicolored spots on them. The ESD confirmed all findings on the	21695	Corrected	

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21695	Continued From page 11 second floor during tour. The ESD stated the carpet was cleaned by himself and a professional carpet cleaning company during the week. The ESD also stated the carpet may not be dried thoroughly, explaining why there were still multicolored spots contrasting from the color of the carpet. On 8/21/14, at 2:45 p.m. the spots appeared the same as they had during tour with ESD. On the 3rd floor, three of twelve chairs in the special care unit and two of ten chairs in the third floor transitional care unit had dried multicolored spots on them. Also in the third floor common area, one of two chairs near the fireplace had a tear and dried spots on it and a couch in the common area had dried black spots on it. The ESD confirmed findings throughout the tour. The undated Rotary Scrub Carpet and Carpet Shampooing and Extracting policies and procedures directed staff, "It is the policy of Marian Center to maintain clean, hygienic carpets, free of soil and debris at all times." The directions also included how to use the equipment and procedures to thoroughly clean carpet. However, the policy did not direct staff as to how frequent carpet cleaning was required. SUGGESTED METHOD OF CORRECTION: The administrator, environmental services director or designee (s) could develop and implement policies and procedures to ensure the environment including the furniture, carpeting, and door frames throughout the facility were clean and in good repair; educate staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.	21695		

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21695	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation and interview, 6 of 6 residents (R109, R27, R25, R94, R105, R24) who ate in their rooms were served food in plastic dishes with plastic silverware and 1 of 4 dining rooms observed for the evening meal; residents were served dessert and salad in plastic dishes. This had the potiental to affect approximately 25 of the 80 residents in the facility. Findings include: The evening meal was observed in the second floor main dining room (DR) on 8/19/14, at 4:30 p.m. Residents who chose the cold beet salad were served the salad in plastic dishes and all of the desserts were served in plastic serving cups. At 5:15 p.m., room trays were prepared for six residents who ate in their rooms. All trays were prepared with plastic silverware in addition to the dessert and beets in plastic serving cups. 8/19/14, at 4:35 p.m. the dietary manager (DM) was interviewed and stated, "maybe we ran out of glass bowls, otherwise the food should be served in glass bowls." When interviewed on 8/19/14 at	21805	Corrected	9/11/14

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21805	Continued From page 13 5:20 p.m., nursing assistant (NA)-A explained that the kitchen does not send up real silverware for the room trays. "We've never been given real silverware for the room trays." NA-A indicated that maybe there wasn't enough real silverware. On 8/20/14, at 10:30 a.m., the DM was interviewed and indicated there may be a shortage of silverware and that was why plastic was used. Although no residents complained regarding use of the plastic dishes and silverware, the DM verified that plastic should not routinely be used. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s) could develop and implement policies and procedures to ensure all residents receive courteous treatment and respect for their individuality by all staff; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse,	22000		9/11/14

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22000	Continued From page 14 and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	22000		

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22000	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report and thoroughly investigate an allegation of potential mistreatment for 1 of 3 residents (R77) reviewed for abuse prohibition. Findings Include: R77 was interviewed on 8/19/14, at 1:43 p.m., and reported how a nursing assistant (NA)-C yelled at him while he was taking a shower several months ago. R77 explained he thought NA-C wanted him to cross his arms and when that was wrong, NA-C yelled at him again, indicating to do something else. R77 stated he was not hard of hearing and didn't think NA-C needed to yell at him. R77 was unsure whether he had told anyone, but stated other staff persons had heard the yelling. He recalled that the clinical manager/licensed practical nurse (LPN)-B had spoken with him the next day and asked if he wanted NA-C to care for him again, and R77 said he did not. R77 stated NA-C had not cared for him since the incident. Review of the last quarterly Minimum Data Set (MDS), dated 5/16/14, identified R77 was cognitively intact with a BIMS (brief interview for mental status) assessment score of 15, had no behaviors, needed extensive assist from staff for transfers, dressing and weight bearing support. LPN-B was interviewed on 8/20/14, at 10:50 a.m. regarding the incident with R77. LPN-B recalled that it had happened several months ago. LPN-B explained that R77 had told the evening staff nurse about the incident and the evening nurse had left a message for LPN-B, the clinical manager, to talk with R77 the next morning. LPN-B verified having interviewed R77 regarding	22000	Corrected	

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22000	Continued From page 16	22000		

the incident the next morning and added that other staff had also been interviewed. LPN-B confirmed NA-C did not work with R77 again and that shortly afterwards, R77 had moved to another floor. LPN-B also stated NA-C had a loud voice and that the concern had been addressed. LPN-B verified there was no documentation from her regarding the message left by the evening nurse, the interview with R77 or with other staff. When LPN-B was asked who else was aware of the incident, she stated the social services staff for the unit had also been notified at the time of the incident.
On 8/20/14, at 11:20 a.m., the unit's social worker (SW) was interviewed and did not recall having information regarding the described incident. Review of R77's medical record lacked any documentation regarding the incident between NA-C and R77 from the reporting staff nurse or from LPN-B.
A review of NA-C's personal record included an "Employee-Supervisor Conference Form" dated 6/24/14. The form indicated NA-C had received a verbal warning and addressed several areas. Facts: "per resident [R77] interview, NAR (nursing assistant registered) [NA-C] yelled at him when he didn't understand what she was asking." Objectives: "Treat everyone with respect. Resident's treated with dignity and compassion." Solutions: "Will attend annual skills fair, customer service training." And Action: "Disciplinary action will proceed to next level if behavior continues." The form was signed by LPN-B on 6/24/14. The alleged employee [NA-C] refused to sign the form and wrote: "I don't agree with this because the residents don't understand what I am saying to them." The employee conference form was provided to survey staff by the administrator on 8/21/14, at 10:50 a.m. The administrator stated, "this is related to the incident

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22000	Continued From page 17 resident [R77] reported." The director of nursing (DON) and the director of social services (DSS) were interviewed on 8/20/14, at 1:00 p.m. When informed of the incident between R77 and NA-C, the DON stated the incident should have been reported and investigated immediately, but denied having been previously informed of the incident. The DON then called LPN-B, the clinical manager, for additional details. LPN-B informed the DON of the incident between NA-C and R77 which included information regarding staff personality, not getting along, and a verification that R77 had not been harmed. The facility's Abuse Prevention Plan Policy last revised on 10/11, identified Abuse as: "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. On page 4 under Investigation of Incidents and Allegations, bullet a. read: "All accidents, incidents as well as allegations of abuse or neglect will be investigated by the Director of Social Services, Director of Nursing or Designee." On page 5 under the heading; "Reporting of Suspected Resident Abuse, Neglect and or Crime" the information included: "Staff will notify the facility Charge of Building immediately of any report of possible abuse or neglect. The Charge of Building (COB) will immediately notify the Administrator, Director of Nursing and Director of Social Services or designee." In the procedure, "Vulnerable adult Reporting and Investigation" last revised 10/11, bullet 1.) included: "Staff will notify the Administrator, Director of Nursing (DON) and Director of Social Services (DSS) immediately upon witnessing or receiving a report of mistreatment, neglect, or	22000		

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22000	Continued From page 18 abuse, including injuries of unknown source, and misappropriation of resident property. If the DON or DSS are unavailable or it is an evening, weekend, or holiday the report will be made to the Charge of Building who will in turn contact the DON or DSS. The COB will follow the Vulnerable Adult Action Plans." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies are followed, that staff are fully trained and that audits are performed to assure thorough reports have been written and appropriate staff, residents and family are interviewed during the process to assure all residents are free from mistreatment. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	22000		