DEPARTMENT OF HEALTH AND) HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDI	CAID SERVICES
	MEDIC	ARE/MEDICAII	O CERTIFIC	CATION A	AND TRANSMITTAL		ID: EWNF
]	PART I -	TO BE COMPL	ETED BY 1	THE STAT	TE SURVEY AGENCY		Facility ID: 00354
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245365 2.STATE VENDOR OR MEDICAID NO. (L2) 723816900		 NAME AND AD (L3) CERENITY (L4) 200 EARL S⁴ (L5) SAINT PAUL 	CARE CENT TREET		IAN (L6) 55106	 TYPE OF ACTI Initial Termination Validation 	ION: <u>7 (</u> L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNER (L9)	SHIP	7. PROVIDER/SU	,	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 8. Full Survey Aft 	9. Other er Complaint
6. DATE OF SURVEY 10/22/2014 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END 09/30	DING DATE: (L35)
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 	(L18)	Compliance	nce With equirements	AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of S 7. Medical D	Services Limit Director om Size
13.Total Certified Beds 90	(L17)		pliance with Prog ents and/or Appli		* Code: A*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF 90	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS (I Mandatory DPNA, effective 11/				,			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Sue Miller, HFE NE II		1	0/23/2014	(L19)	Anne Kleppe, Enforcer	ment Specialist	10/23/2014 (L20)
PART II -	TO BE	COMPLETED B	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	(120)
 19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u>2</u>. Facility is not Eligible 		20. COM	PLIANCE WITH		21. 1. Statement of Finar	ncial Solvency (HCFA-25 ol Interest Disclosure Strr	
22. ORIGINAL DATE 23. 17	C AGREE	MENT 24	. LTC AGREEN	/FNT	26. TERMINATION ACTION:		(L30)
	EGINNING		ENDING DA		VOLUNTARY 00 01-Merger, Closure 00	INVOLU	J <u>NTARY</u> o Meet Health/Safety
(L24) (I	A1)		(L25)		02-Dissatisfaction W/ Reimburse		o Meet Agreement
(1.27)	Suspensio	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	der Status Change
			(L45)				
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
(L2:	8)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
(L32	2)	09/24/2014		(L33)	DETERMINATION APPI	ROVAL	



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 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:

Cerenity Care Center - Marian October 23, 2014 Page 2

• 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,

Are Kleepe

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,

Are Klegge

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

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

Cerenity Care Center - Marian October 20, 2014 Page 2

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.

Cerenity Care Center - Marian October 20, 2014 Page 3

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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,

Are Klegge

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245365	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/22/2014
Name	e of Facility		Street Address, City, State, Zip Code	
CE	RENITY 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
	F0225 483.13(c)(1)(ii)-((1 (iii), (c)(2)		0	F0226 483.13(c)		Correction Completed 10/17/2014			F0241 483.15(a)		Correction Completed 10/17/2014
	F0282 483.20(k)(3)(ii)	(1	Correction Completed I 0/17/2014		F0312 483.25(a)(3)		Correction Completed 10/17/2014			F0356 483.30(e)		Correction Completed 10/17/2014
	F0371 483.35(i)	(1	Correction Completed I0/17/2014	ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 10/17/2014		Reg. #			Correction Completed
Reg. #			Correction Completed									
Reg. #			Correction Completed						D //			
Reviewed B State Agen Reviewed B CMS RO	cy SR	eviewed 2/AK eviewed	-	Date: 10/23/20 Date:	Signature 114 Signature		•		03023	3	Date: 10/ Date:	22/2014
Followup t	o Survey Compl 8/21/20				Check for an Uncorrecte					Summary of the Facility?	YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00354	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/22/2014
Name	e of Facility		Street Address, City, State, Zip Code	
CE	RENITY 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) D	ate
	MN Rule 4658.0405 Subp.		20920 10 MN Rule 4658.0525 Subp.			MN Rule 4658.0650 Su	-
ID Prefix	Correction Completed 21695 10/17/2014	ID Prefix	C	orrection ompleted D/17/2014	ID Prefix	22000	Correction Completed 10/17/2014
Reg. # LSC	MN Rule 4658.1415 Subp.		MN St. Statute 144.651 St			MN St. Statute 626.557	
ID Prefix Reg. # LSC	Correction Completed	Reg. #		orrection ompleted	ID Prefix Reg. # LSC		
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		orrection ompleted	Reg. #		
ID Prefix Reg. # LSC	Correction Completed	Reg. #		orrection ompleted	ID Prefix Reg. # LSC		Correction Completed
Reviewed E State Agene Reviewed E	cy SR/AK	Date: 10/23/201 Date:	4 Signature of Surve		03023	Date: 10/22	/2014
	o Survey Completed on: 8/21/2014 M: REVISIT REPORT (5/99)		Check for any Uncorre Uncorrected Deficie Page 1 of 1				NO

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES
	MEDIC	ARE/MEDICAL	D CERTIFIC	CATION	AND TRANSMITTAL		ID: EWNF
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	FE SURVEY AGENCY	1	Facility ID: 00354
1. MEDICARE/MEDICAID PROVIDER (L1) 245365		3. NAME AND AL (L3) CERENITY	CARE CENT		RIAN	4. TYPE OF ACTI	ON: <u>2</u> (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 723816900).	(L4) 200 EARL S (L5) SAINT PAU			(L6) 55106	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey Aft	
6. DATE OF SURVEY 08/21 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR END 09/30	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY		18.			
From (a):		A. In Complia		710.	And/Or Approved Waivers Of	The Following Requirer	nents:
To (b):		Program R	equirements		2. Technical Personnel		
	00 (110)	1	e Based On:		 3. 24 Hour RN 4. 7-Day RN (Rural SN 	7. Medical D	
12.Total Facility Beds	90 (L18)	1. A	cceptable POC		5. Life Safety Code	NF) <u>8.</u> Patient Roo 9. Beds/Roor	
13.Total Certified Beds	90 (L17)	X B. Not in Con Requirement	npliance with Pro ents and/or Appl		* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS		
18 SNF 18/19 SNF 90	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Candace Bolduc, HFE NE I	Ι		09/16/2014	(L19)	Anne Kleppe, Enforcen	nent Specialist	09/19/2014 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBILI			IPLIANCE WIT HTS ACT:	H CIVIL	 1. Statement of Fina 2. Ownership/Contro 3. Both of the Above 	ol Interest Disclosure Stm	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 11/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>	
	A. Suspensio	n of Admissions:			04-Other Reason for Withdrawal		der Status Change
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active	2
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



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,

Are Klegge

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB	3 NO. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION (X: G	3) DATE SURVEY COMPLETED
		245365	B. WING _		08/21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CERENIT	Y CARE CENTER - M			200 EARL STREET	
UERENI				SAINT PAUL, MN 55106	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 000	INITIAL COMMENT	rs	F 00	0	
F 225 SS=D	as your allegation of Department's accept bottom of the first pr be used as verificat Upon receipt of an revisit of your facilit validate that substaregulations has bee your verification.	(c)(2) - (4)	F 22	Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/ 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 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 white are in violation of the state statute after the statement, "This Rule is not met a evidenced by." Following the surveyor 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. TH WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION I VIOLATIONS OF MINNESOTA STATI STATUTES/RULES.	e/rule ch er as rs f G IIS
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically 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.

		AND HUMAN SERVICES			FORM	: 09/18/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245365	B. WING		08/	21/2014
NAME OF I	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE		
CERENI	TY CARE CENTER - M	IARIAN		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	COMPLETION DATE
F 225	Continued From pa	ae 1	F 225	5		
	The facility must no	ot employ individuals who have				
		f abusing, neglecting, or ts by a court of law; or have				
		ed into the State nurse aide				
		abuse, neglect, mistreatment appropriation of their property;				
		wledge it has of actions by a				
	0	t an employee, which would				
		or service as a nurse aide or the State nurse aide registry				
	or licensing authori					
	involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established	nsure that all alleged violations nent, neglect, or abuse, i unknown source and i resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).				
	The facility must ha violations are thoro	ave evidence that all alleged ughly investigated, and must ential abuse while the				
	to the administrator representative and with State law (inclu- certification agency incident, and if the	vestigations must be reported r or his designated to other officials in accordance uding to the State survey and r) within 5 working days of the alleged violation is verified ive action must be taken.				
	This REQUIREMEI	NT is not met as evidenced				
		v and document review, the		Cerenity Senior Care	- Marian of Saint	

If continuation sheet Page 2 of 22

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCT		OMB NO.	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G			PLETED	
		245365	B. WING _			08/2	21/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CC	DDE		
CERENI	TY CARE CENTER - N	IARIAN	200 EARL STREET SAINT PAUL, MN 55106					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORI CORRECTIVE ACTION S REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 225	Continued From pa	ge 2	F 22	5				
	facility failed to imm investigate an alleg for 1 of 3 residents prohibition. Findings Include: R77 was interviewe and reported how a yelled at him while several months ago NA-C wanted him to that was wrong, NA indicating to do som was not hard of hea needed to yell at him he had told anyone had heard the yellin manager/licensed p spoken with him the wanted NA-C to can he did not. R77 sta him since the incide Review of the last of (MDS), dated 5/16/ cognitively intact wi mental status) asse behaviors, needed transfers, dressing LPN-B was intervier regarding the incide that it had happene explained that R77 nurse about the inc had left a message manager, to talk wi LPN-B verified havit the incident the next	addiately report and thoroughly ation of potential mistreatment (R77) reviewed for abuse ad on 8/19/14, at 1:43 p.m., a nursing assistant (NA)-C he was taking a shower b. R77 explained he thought o cross his arms and when a-C yelled at him again, mething else. R77 stated he aring and didn't think NA-C m. R77 was unsure whether , but stated other staff persons and. He recalled that the clinical bractical nurse (LPN)-B had a next day and asked if he re for him again, and R77 said ated NA-C had not cared for	Γ 22	Paul's Cre has been p Submissio Complaina a deficience of the Defi and is also admission its Adminis agents or of may be dis Allegation preparatio Credicble J not contsit of any kind facts alleg conclusion the survey submitting Compliance federal law Credible A ten(10) ca Statement particopate Assistance the Credible within this considered with the all admission	dible Allegation of prepared and time on of this Credible A ace is not a legal a cy exists or that the ciencies were corr o not to be construe against interest of strator or any empl other individuals w scussed in thie Cre of Complaince. In n and submission Allegation of Comp oute an admission of by Facility of the ed or the correction is set forth in this a pagency. According this Credible Allegation this Credible Allegation of Compl lendar days of rece of Deficincies as a e in the Medicare a programs. The su- le Allegation of Compl lendar days of non- c by the Facility.	ly submitted. Allegation of dmission that e Statement ectly sited, ed as an f the Facility, oyees, tho draft or edible addtion, of this bliance does or agreement truth of any ess of any allegation by gy, we are gation of state and sion of a iance within eipt of the a condition to and Medical ubmission of mpliance or		

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245365 08/21/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET **CERENITY CARE CENTER - MARIAN** SAINT PAUL, MN 55106 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 225 Continued From page 3 F 225 another floor. LPN-B also stated NA-C had a facility policy dated 5/10/14 which was loud voice and that the concern had been provided the surveyors at the time of the survey and according to federal law. addressed. LPN-B verified there was no At the time the incident was reported by documentation from her regarding the message left by the evening nurse, the interview with R77 R77 an investigation occurred and abuse or with other staff. When LPN-B was asked who was immediately ruled out. R77 stated he else was aware of the incident, she stated the did not want a change in caregiver and he social services staff for the unit had also been re-stated that she spoke loudly but did not " yell" at him. When the surveyors arrived notified at the time of the incident. On 8/20/14, at 11:20 a.m., the unit's social worker and re-ivinterviewed R77 we did file the (SW) was interviewed and did not recall having incident to appropriate agency based on information regarding the described incident. surveyor interpretation of the report. The Review of R77's medical record lacked any Minnesota Department of Health Office of documentation regarding the incident between Health Facility Complaints deteremined NA-C and R77 from the reporting staff nurse or that no further action was necessary . from LPN-B. A review of NA-C's personal record included an Corrective action will be achieved by "Employee-Supervisor Conference Form" dated re-educating all staff on the facility Abuse 6/24/14. The form indicated NA-C had received a Prevention Plan. verbal warning and addressed several areas. The facility will continue to report all Facts: "per resident [R77] interview, NAR (nursing allegations of mistreatment to the Director assistant registered) [NA-C] yelled at him when of Social Service, Director of Nursing and he didn't understand what she was asking." the Administrator. The facility IDT Objectives: "Treat everyone with respect. (Interdisplinary Team) reviews all resident Resident's treated with dignity and compassion." incidents in the morning report meeting as Solutions: "Will attend annual skills fair, well to assure thorough follow up. The customer service training." And Action: facility will conduct thorough investigations "Disciplinary action will proceed to next level if of all allegations of mistreatment. behavior continues." The form was signed by The Director of Social Service is LPN-B on 6/24/14. The alleged employee [NA-C] responsible for evaluating the refused to sign the form and wrote: "I don't agree effectiveness of this plan. with this because the residents don't understand The outcome of this plan will be reviewed what I am saying to them." The employee at the next Quarterly Quality Assurance conference form was provided to survey staff by Council Meeting and ongoing as needed. 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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN	F OF DEFICIENCIES DF CORRECTION	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245365		NG		10 4 10 0 4 4
	PROVIDER OR SUPPLIER	243365	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	08	/21/2014
				200 EARL STREET		
CERENI	TY CARE CENTER - N	IARIAN		SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 225	social services (DS 8/20/14, at 1:00 p.m incident between R the incident should investigated immed previously informed then called LPN-B, additional details. If the incident between included informatio not getting along, a not been harmed. The facility's Abuse revised on 10/11, ic infliction of injury, u intimidation, or pun harm, pain or ment Investigation of Inc. read: "All accidents allegations of abuse investigated by the Director of Nursing under the heading; Resident Abuse, Ne information include Charge of Building possible abuse or r Building (COB) will Administrator, Direc Social Services or of In the procedure, "N Investigation" last r included: "Staff will Director of Nursing Services (DSS) imr receiving a report of abuse, including inj	S) were interviewed on n. When informed of the 77 and NA-C, the DON stated have been reported and liately, but denied having been d of the incident. The DON the clinical manager, for LPN-B informed the DON of en NA-C and R77 which n regarding staff personality, nd a verification that R77 had Prevention Plan Policy last dentified Abuse as: "The willful nreasonable confinement, ishment with resulting physical al anguish. On page 4 under idents and Allegations, bullet a. s, incidents as well as e or neglect will be Director of Social Services, or Designee." On page 5 "Reporting of Suspected eglect and or Crime" the d: "Staff will notify the facility immediately of any report of neglect. The Charge of immediately notify the ctor of Nursing and Director of	F 2:			

If continuation sheet Page 5 of 22

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DAT	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		IG	· · ·	IPLETED
		245365	B. WING _		08/	21/2014
AME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ERENI	TY CARE CENTER - M	IARIAN		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 225	Continued From pa	ge 5	F 22	25		
		able or it is an evening,				
		y the report will be made to the				
		who will in turn contact the COB will follow the Vulnerable				
	Adult Action Plans.					
F 226 SS=D	483.13(c) DEVELO ABUSE/NEGLECT		F 22	26		10/17/14
	policies and procec mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.				
		NT is not met as evidenced				
	by: Based on interview	v and document review, the		It is the policy of Cerenity Senio	r Care-	
		lement their Abuse Prevention		Marian of Saint Paul to thorough investigate any and all allegation	ly	
	administrator, direc	etor of nursing (DON), the ervices (DSS), and failed to		mistreatment and report accordi facility policy dated 5/10/14 whic	ng to h was	
		investigation of an allegation 1 of 3 residents (R77) prohibition.		provided the surveyors at the tim survey and according to federal At the time the incident was repo	law.	
	Findings Include:			R77 an investigation occurred ar was immediately ruled out. R77 did not want a change in caregiv	stated he	
	revised on 10/11, ic	Prevention Plan Policy last lentified Abuse as: "The willful		re-stated that she spoke loudly b " yell" at him. When the surveyor	out did not is arrived	
	intimidation, or pun	nreasonable confinement, ishment with resulting physical al anguish." On page 4 under		and re-ivinterviewed R77 we did incident to appropriate agency b surveyor interpretation of the rep	ased on	
	the heading, Invest Allegations, bullet A incidents as well as	igation of Incidents and A. included: "All accidents, a allegations of abuse or		Minnesota Department of Health Health Facility Complaints deter that no further action was neces	Office of emined	
	neglect will be inve	stigated by the Director of rector of Nursing or Designee."		Corrective action will be achieve	-	

Facility ID: 00354

If continuation sheet Page 6 of 22

TATEMEN	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245365			08/2	21/2014
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, Z		. 1/2014
CERENI	TY CARE CENTER - N	IARIAN		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 226	On page 5 under the Suspected Residen Crime" the informati the facility Charge of report of possible a of Building (COB) w Administrator, Direct Social Services or of The facility's proced Reporting and Inves Bullet 1 included: " Administrator, Direct Director of Social S upon witnessing or mistreatment, negle of unknown source resident property. I unavailable or it is a holiday the report w Building who will in The COB will follow Plans." R77 was interviewe and reported how a yelled at him while I several months ago NA-C wanted him to that was wrong, NA indicating to do son was not hard of hea needed to yell at hin to be yelled at and a whether he had tolo persons had heard the clinical manage (LPN)-B had spoke	te heading; "Reporting of the Abuse, Neglect and or tion included: "Staff will notify of Building immediately of any buse or neglect. The Charge vill immediately notify the ctor of Nursing and Director of designee." dure "Vulnerable adult stigation" last revised 10/11,	F 22	re-educating all staff on the Prevention Plan and assisting implementation of the port of facility will continue the allegations of mistreatment of Social Service, Director the Administrator. The facility conduct the administrator. The facility will conduct thorous of all allegations of mistreatment of all allegations of mistreatment from the outcome of this plane. The outcome of this plane at the next Quarterly Quarter	uring licy. o report all ent to the Director or of Nursing and cility IDT views all resident report meeting as ollow up. The ugh investigations eatment. ervice is g the will be reviewed ality Assurance	

If continuation sheet Page 7 of 22

		AND HUMAN SERVICES				FORM	: 09/18/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245365	B. WING			08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	Y CARE CENTER - N	IARIAN			00 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	NA-C had not cared R77's most recent of (MDS) dated 5/16/1 cognitively intact wi mental status) asset the highest score in impairment), experi- requiring extensive dressing and weigh LPN-B was intervier regarding the incide that it had happene explained that R77 nurse about the inc- had left a message manager, to talk wit LPN-B verified havi the incident the nex- other staff had also confirmed NA-C dio that shortly afterwal another floor. LPN- loud voice and that addressed. LPN-B documentation from left by the evening or with other staff. else was aware of t social services staff notified at the time On 8/20/14, at 11:2 (SW) was interview	and he'd agreed. R77 stated d for him since the incident. quarterly Minimum Data Set 14, identified R77 as th a BIMS (brief interview for essment score of 15 (15 being ndicating no cognitive ienced no behaviors, and as assist from staff for transfers, it bearing support. ewed on 8/20/14, at 10:50 a.m. ent with R77. LPN-B recalled d several months ago. LPN-B had told the evening staff ident and the evening nurse for LPN-B, the clinical th R77 the next morning. ng interviewed R77 regarding tt morning and added that been interviewed. LPN-B d not work with R77 again and rds, R77 had moved to -B also stated NA-C had a the concern had been verified there was no n her regarding the message nurse, the interview with R77 When LPN-B was asked who he incident, she state the f for the unit had also been of the incident. 0 a.m. the unit's social worker red, she did not recall having report/information regarding	F 2	226			

If continuation sheet Page 8 of 22

		AND HUMAN SERVICES				FORM	09/18/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245365	B. WING			08/:	21/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	Y CARE CENTER - N	IARIAN			00 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	Review of R77's m documentation rega NA-C and R77 from from LPN-B. A review of NA-C's "Employee-Supervi 6/24/14. The form verbal warning and Facts: "per resident assistant registered he didn't understan Objectives: "Treat Resident's treated w Solutions: "Will attact customer service tr "Disciplinary action behavior continues LPN-B on 6/24/14. refused to sign the with this because th what I am saying to conference form wa the administrator or administrator stated resident [R77] repo The director of nurs social services (DS 8/20/14, at 1:00 p.n incident, the DON been reported and denied having beer incident. The DON manager, to get add informed the DON	edical record lacked any arding the incident between in the reporting staff nurse or personal record included an sor Conference Form" dated indicated NA-C had received a addressed several areas. t [R77] interview, NAR (nursing d) [NA-C] yelled at him when d what she was asking." everyone with respect. with dignity and compassion." end annual skills fair, aining." And Action: will proceed to next level if ." The form was signed by The alleged employee [NA-C] form and wrote: "I don't agree he residents don't understand o them." The employee as provided to survey staff by n 8/21/14, at 10:50 a.m. The d, "this is related to the incident	F2	226			

Facility ID: 00354

If continuation sheet Page 9 of 22

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/18/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	E SURVEY PLETED
		245365	B. WING			08/2	21/2014
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	Y CARE CENTER - N	IARIAN			00 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From pa harmed.	ge 9	F 2	226			
F 241 SS=B	incident, the NA-C I verbal warning, and care for R77, there filled out, and no do administrator, the D been promptly notif addition, there was of the incident that investigation had be whether mistreatme 483.15(a) DIGNITY INDIVIDUALITY The facility must pro-	aff had been aware of the had received a disciplinary d NA-C no longer provided had been no incident report ocumentation to indicate the DON, the DSS or designee had ied of the allegation. In no documentation at the time revealed any type of een conducted to determine ent had occurred with R77. AND RESPECT OF	F2	241			10/17/14
	enhances each res full recognition of hi	nvironment that maintains or ident's dignity and respect in is or her individuality. NT is not met as evidenced					
	residents (R109, R2 ate in their rooms w dishes with plastic s rooms observed for were served desset This had the potien of the 80 residents Findings include: The evening meal w floor main dining ro p.m. Residents who were served the sa	tion and interview, 6 of 6 27, R25, R94, R105, R24) who vere served food in plastic silverware and 1 of 4 dining the evening meal; residents and salad in plastic dishes. tal to affect approximately 25 in the facility. was observed in the second om (DR) on 8/19/14, at 4:30 o chose the cold beet salad lad in plastic dishes and all of served in plastic serving cups.			All residents will be served meals us non- disposable siverware and plates We purchased additional tableware t support this plan. The facility policy we revised to reflect this change. All Dietary staff will be provided educe regarding the policy. The Director of Culinary Services or designee will au varied meals three times per week times weeks, one time per week times weeks and one time per month as needed. The Director of Culinary Services will be responsible for implementatio evaluation of the effectiveness of this	s. to was ucation udit imes s three rvices on and	

Facility ID: 00354

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245365 B. WING 08/21/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET **CERENITY CARE CENTER - MARIAN** SAINT PAUL, MN 55106 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 10 F 241 At 5:15 p.m., room trays were prepared for six plan. 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 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 10/17/14 PERSONS/PER CARE PLAN SS=D 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 R125's nail care was corrected by review, the facility did not follow the individualized immediately providing nail care during the care plan for nail care for 1 of 1 resident (R125) survey. reviewed for hospice. During the residents bath or shower the nurse will assure the residents nails are Findings include: clean and trimmed.

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) [IO. 0938-039 DATE SURVEY COMPLETED
		DENTIFICATION NOMBER.	A. BUILDII	NG		
		245365	B. WING _)8/21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CERENI	Y CARE CENTER - I	MARIAN		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 11	F 28	82		
	member (FM)-B or expressed concerr	v conducted with family n 8/19/14, at 2:05 p.m., FM-B ns related to R125's grooming to staff not cleaning sident's fingernails.		The facility will idenity othe need of nail care by comp weekly times one month a times three months and th based on outcomes.	leting audits Ind monthly	
		e plan dated as initiated taff: "Nail Care on bath day by				
	R125 was up and o wheelchair. R125' to have chipped pin observed to be soi debris. Nursing as R125's fingernails that there was deb stated that R125 h (8/17/14) by facility again on Thursday	tion on 8/20/14, at 10:37 a.m. dressed in a tilt/recline s fingernail tips were observed nk nail polish. The nails were led underneath with blackish sistant (NA)-B confirmed were partially unpolished and ris under the fingernails. NA-B ad been bathed on Sunday staff and would be bathed (8/21/14) by a hospice aide. s nails were supposed to be h time.				
	registered nurse (F two NA's to provide at R125's fingernai were not clean. RI R125's hands were was observed to w R125's hands, how	/20/14, clinical manager RN)-A, was observed to assist e care for R125. RN-A looked ils and acknowledged they N-A asked NA-B to make sure e washed. At 10:44 a.m. NA-B heel R125 to her room to wash vever, NA-B did not clean or inderneath R125's nails.				
	RN-A explained that facility and the hos	icted on 8/21/14, at 12:39 p.m. at nursing assistants from the pice were responsible to or R125 on her bath days which				

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	OF DEFICIENCIES	& MEDICAID SERVICES			B NO. 0938-039 3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		(X	COMPLETED
		245365	B. WING		08/21/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CERENI	TY CARE CENTER - N	IARIAN		200 EARL STREET SAINT PAUL, MN 55106	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 282	were Sunday and T dependent residen	Fhursday. RN-A said ts' nails should be trimmed and ay, and should be checked with	F 282		
F 312 SS=D		CARE PROVIDED FOR	F 312		10/17/14
	daily living receives	nable to carry out activities of the necessary services to ition, grooming, and personal			
	by: Based on observa review, the facility of nail care was provi- reviewed for hospic Findings include: During an observat R125 was observe wheelchair while w registered nurse (R dinner. At that time	NT is not met as evidenced tion, interview, and record did not assure that appropriate ded for 1 of 1 resident (R125) ce care. tion on 8/18/14, at 4:45 p.m. d sitting up in a tilt/recline type aiting for dinner. At 5:04 p.m. RN)-B served the resident her e, R125's nails were observed ially painted pink on the ends		R125's nail care was corrected by immediately providing nail care during survey. During the residents bath or shower th nurse will assure the residents nails a clean and trimmed. The facility will idenity other residents need of nail care by completing audits weekly times one month and monthly times three months and then as need based on outcomes.	ne re in
	During an interview member (FM)-B or expressed concern	v conducted with family a 8/19/14, at 2:05 p.m., FM-B as related to R125's grooming to staff not cleaning ident's fingernails.			

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	F OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
	DI CONRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G	00	
		245365			08	/21/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER - I	MARIAN		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 312	R125 was up and o wheelchair. R125' to have chipped pin observed to be soil debris. Nursing as R125's fingernails that there was deb stated that R125 has (8/17/14) by facility again on Thursday NA-B stated R125' cleaned during bat At 10:40 a.m. on 8, was observed to as for R125. RN-A loo acknowledged they NA-B to make sure At 10:44 a.m. NA-E to her room to was NA-B did not clean underneath R125's During an interview 12:39 p.m. RN-A e assistants from the responsible to prov bath days, Sunday R125's nails should (including underne checked with cares RN-A indicated R1 yesterday, after it w 12:55 p.m. RN-A a R125's fingernails been cleaned adeo	dressed in a tilt/recline s fingernail tips were observed nk nail polish. The nails were led underneath with blackish sistant (NA)-B confirmed were partially unpolished and ris under the fingernails. NA-B ad been bathed on Sunday y staff and would be bathed (8/21/14) by a hospice aide. s nails were supposed to be h time. /20/14, clinical manager RN-A, sist two NA's to provide care oked at R125's fingernails and y were not clean. RN-A asked e R125's hands were washed. B was observed to wheel R125 h R125's hands, however, or attempt to clean	F 31:			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245365 B. WING 08/21/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET **CERENITY CARE CENTER - MARIAN** SAINT PAUL, MN 55106 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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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		AND HUMAN SERVICES			FORM	09/18/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245365	B. WING		08/;	21/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	Y CARE CENTER - N	IARIAN		00 EARL STREET AINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 F 356 SS=C	Goal: Resident will season appropriate The facility's Policy Toenails undated, in cleanliness, preven prevent injury by co appropriate. Weari and "soak nails firs procedure following a nail brush for clean necessary." 483.30(e) POSTED INFORMATION The facility must por a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sh - Registered nu - Licensed prac vocational nurses (a - Certified nurses o Resident census. The facility must por specified above on of each shift. Data o Clear and readab o In a prominent pla residents and visito	and the actual hours worked egories of licensed and staff directly responsible for hift: rses. tical nurses or licensed as defined under State law). e aides.	F 312			10/17/14

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/18/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245365	B. WING			08/2	21/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	Y CARE CENTER - N	IARIAN			00 EARL STREET AINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	for review at a cost standard. The facility must mass staffing data for a mass required by State lat This REQUIREMENT by: Based on observation interview, the facility staff nursing inform census or the actuat discipline, per shift. Findings include: Observations on 8/ staff posting was of inaccurate census, hours worked by dis At 2:00 p.m. on 8/1 conducted with the the nurse staff post verified the census and should have be coordinator also ve listed or broken dow staff per shift. At 22 and administrator of nursing information facility failed to inclu- actual hours worked 483.35(i) FOOD PE	a data available to the public not to exceed the community aintain the posted daily nurse hinimum of 18 months, or as w, whichever is greater. NT is not met as evidenced ion, document review and y did not ensure the posted ation included the correct al hours worked by staff 18/14, at 11:30 a.m. of the bserved to identify an and did not identify the actual scipline for each shift. 8/14, an interview was staffing coordinator, regarding ing. The staffing coordinator was incorrectly listed as 79 een 80. The staffing rified shift hours worked by 45 p.m. the director of nursing onfirmed the posting of noted on entrance to the ude the correct census or the d by discipline for each shift. BOCURE,	F 3	356	The facility Director of Nursing and Administrator were notified upon en that the hours posted did not meet t latest CMS (Centers for Medicare a Nedicaid Service) interpretation. Th facility immediately corrected the wa hours are posted and re-posted the to include actual hours worked by jo class and shift. This was approved by the survey te day one of the survey. The facility will monitor its performa order to assure the change in practi sustained by completing an audit of posted nursing hours three times per week times one month and as need thereafter. The Director of Nursing is responsit evaluating the plan for its effectiven The outcome of this plan will be sha the next Quarterly Quality Assurance Council Meeting.	trance the and e ay the hours bb am on nce in ice is the er ded ole for ess. ared at	10/17/14
F 371 SS=F	nursing information facility failed to inclu actual hours worke 483.35(i) FOOD PF	noted on entrance to the ude the correct census or the d by discipline for each shift.	F 3	371	-		10/17/14

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		AND HUMAN SERVICES			PRINTED: 09/18/ FORM APPRC OMB NO. 0938-	OVE
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245365	B. WING		08/21/201	4
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	•	-
CERENI	TY CARE CENTER - M	IARIAN		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLI	ETION
F 371	Continued From pa	ige 17	F 3	71		
	considered satisfact authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food ditions				
	by: Based on observat review, the facility f serve food in a man development of foo potential to affect a residents who rece kitchen. Findings include: On 8/18/14, at 11:5 kitchen was comple (DM). The following The meat slicer wa and the DM stated However, when the food debris was no slicer. The DM agre been cleaned thoro The large sugar an very sticky and soil There were approx	NT is not met as evidenced tion, interview, and document ailed to store, prepare, and oner to minimize the possible of borne illness. This had the pproximately 77 of 80 ived food prepared in the 5 a.m. an initial tour of the eted with the dietary manager g issues were identified: s covered with plastic wrap it was ready for use. e plastic was lifted, some dried ted on the blade of the meat eed the slicer blade had not bughly. d flour bins were noted to be ed on the lids and sides. imately 20-25 small plates and o have been put away wet		The facility will procure for approved or considered sa federal, state and local aut store, prepare, distribute au under sanitary conditions. All residents will be served stored and prepared accor and state regulations to rea foodborne illness. The Director of Culinary Se the specific cleaning assign and has them scheduled in with federal and state regu The Director of Culinary Se reviewed these changes w staff on 8/24/14 and additio 9/3/14. The Nutritional Supplemen revised to assure expiration self stable nutritional suppl staff were educated on this meetings on 8/24/14 and 9 The proper dating and disp	tifactory by horities and nd serve food food that is ding to federal duce the risk of ervices revised ments for staff a acccordance lations. ervices ith the dietary onally on t Policy was n dates of non- ements. Dietary s in the /3/14.	

Facility ID: 00354

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245365 08/21/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET **CERENITY CARE CENTER - MARIAN** SAINT PAUL, MN 55106 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 18 F 371 A half gallon prepared ham salad was observed by the Director of Culinary Services. in the walk-in-cooler open for use, but not dated The Director of Culinary Services will assure the use of enclosed carts for as to when it had been opened. A half of a 5 pound bag of shredded mozzarella transporting food. The Director of Culinary cheese was observed to have been open for use, Servies and Nurse Managers will train the nursing staff on properly covering food but was undated. while transporting from the kitchenettes out of the dining rooms. During the tour, the DM acknowledged each of We added an additional drying rack for these issues. The DM stated she was new to the DM position in the past month and was just drying dishes. The rinse additive was starting to get a sense of the areas that needed changed to improve drying time. The dish to be worked on. machine temperature tracking tool will be consistently implemented. The Culinary On 8/18/14, at 2:15 p.m., observations in the Services Director reviewed these changes family kitchenette revealed 34 nutritional shakes in the staff meetings on 8/24/14 and were stored in the refrigerator, and had thawed to 9/3/14. liquid form. These single serving shakes had The Director of Culinary Services will audit directions on the labels indicating they were fresh compliance with these changes daily for up to 14 days after being thawed. However, times two weeks, three times weekly none of the shakes had been dated to indicate times one month, weekly times 3 months when they had been taken from the freezer and and then ongoing as needed. placed in the refrigerator. The Director of Culinary Services is responsible for implementing this plan and evaluating the effectiveness of this plan. 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.

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/18/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245365	B. WING		08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZI	IP CODE	
CERENIT	Y CARE CENTER - N	IARIAN		00 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	8/20/14, at 9:30 a.m including salami, tu observed to be ope indication of when t When interviewed of DM stated the expe be dated when ope the mighty shakes, unaware that they r they had been thaw and beverages serve supposed to be cov The facility's policy Nutritional Supplements indicated nutritional supplements which to increase palatabit safety. The policy d the supplements or and thawed. An undated policy a Responsibility of Nut indicated through An undated policy a Equipment Operation indicated the dietary developing cleaning employees were rest	I visit to the kitchen on h., packages of cold cuts rkey, and bologna were ned for use without any hey had been opened. on 8/20/14, at 9:30 a.m. the actation was that foods should ned. When interviewed about the DM stated he was equired a date as to when red. He also stated all food ved as room trays were rered during transport/delivery. and procedure for their nent Program, revised 4/09, services stocked high calorie are stored in the refrigerator ility and to ensure product id not address the dating of nce removed from the freezer and procedure titled ursing Service in Tray Delivery, t remain covered while being	F 371			
F 465 SS=E	procedures. 483.70(h)	L/SANITARY/COMFORTABL	F 465			10/17/14

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		AND HUMAN SERVICES			FORM A	09/18/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245365	B. WING		08/2	1/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER - N	IARIAN		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	Continued From pa	ige 20	F 465	5		
		ovide a safe, functional, ortable environment for the public.				
	by: Based on observative review, the facility for common areas were which had the pote their guests on the door frames were read their guests on the door frames were read the frames and chairs in common were clean and in goar for the frames, and chairs in common were clean and in goar for the initial toor multicolored spots of from the original coand third floor. During the initial too for the frames for the director (ESD) on 8 following observation Significant sections door frames for the the second floor lor R32, R112, R178, France R103, R117, R71, France R100, R117, R71, France R100, R117, R71, France R100, R117, R71, F	NT is not met as evidenced tion, interview, and document ailed to ensure resident re clean and well maintained, ntial to impact 42 residents or 2nd floor and failed to assure naintained in good repair for , R77, R32, R112, R178, R83, 135, R103, R117, R71, R94, hose doors had paint peeling nd failed to assure that tables non spaces on the 3rd floor good repair for approximately their guests to use. ur at noon on 8/18/14, several were noted to be contrasting flor of the carpet on the second e environmental services 8/21/14, at 9:30 a.m. the ons were made: a of paint were peeling from the following residents' rooms on ng term care unit: R102, R77, R83, R97, R143, R84, R135, R94, R125, R81 and R98. a of paint were also noted to be		The facility plan which was communciated to the surveyors by t new Environmental Services Director the time of the survey included make attempts to clean the carpet and if th didnt work we had scheduled a veroe spot and extract carpet on 8/21/14. vendor was unable to get the carpet clean, we had already obtained two for carpet replacement. The vendor attempted to cellan the carpet on 8/2 without success. The carpet for bot and 3rd floor corridors has been ord and will be replaced as soon as ven can obtain and install. The procedures for maintingin the c was revised by the Director of Environmental Services and reviewe the janitorial staff assigned. A sched reventative maintenance program has also been developed to schedule ro cleaning of carpet. The furniture identified during the su to be soiled was cleaned. Furniture was not cleanable was removed and replaced. The procedure for cleaning furniture was revised and was review with the janitorial staff. The schedule preventative maintenance program revised to include routine checks of	or at ing hat dor to lf the bids 21/14 h 2nd lered dor arpet ed with duled as utine urvey that d g the wed ed was	

Facility ID: 00354

If continuation sheet Page 21 of 22

ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		C	(X3) DATE SURVEY COMPLETED	
		245365	B. WING		08/21/2014	
AME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ERENI	Y CARE CENTER - M	IARIAN		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	
F 465	family dining area. Also noted on the sinear room 237. The amount of soiled sp activity/dining room five of fifteen chair on them. The ESD second floor during carpet was cleaned carpet cleaning corr ESD also stated the thoroughly, explain multicolored spots the carpet. On 8/21 appeared the same ESD. On the 3rd floor, this special care unit ar floor transitional ca spots on them. Also area, one of two ch tear and dried spots common area had ESD confirmed find The undated Rotary Shampooing and E procedures directed Marian Center to m carpets, free of soil directions also inclu- equipment and pro-	econd floor family room and becond floor, tile was cracked e carpet had a significant bots. In the second floor , two tables were chipped and s had dried multicolored spots confirmed all findings on the tour. The ESD stated the l by himself and a professional npany during the week. The e carpet may not be dried ing why there were still contrasting from the color of /14, at 2:45 p.m. the spots e as they had during tour with the third floor common airs near the fireplace had a s on it and a couch in the dried black spots on it. The lings throughout the tour. y Scrub Carpet and Carpet xtracting policies and d staff, "It is the policy of raintain clean, hygienic and debris at all times." The uded how to use the cedures to thoroughly clean he policy did not direct staff as	F 465	 furniture and cleaning as needed. A weekly environmental observation be conducted by the Director of Environmental Services or designed items identified will be corrected. results of the observations will be reviewed at the quarterly Quality Assurance Council Meeting. The door frames are being sandeed painted and walls identified in the room and dining areas will be pain complete audit of all areas was co by the Director of Environmental S and all areas identified will be corr The facility will continue the currer order process and also weekly observations by the Director of Environmental Services or designed be conducted to identify areas need attention ongoing. The cracked tiles noted have beer repaired. The weekly observations Director of Environmental Services identify further tile repairs needed will assure they are repaired. The Director of Environmental Services identify for evaluation of this p The weekly onbservations results reviewed at the quarterly Quality Assurance Council Meeting. 	ee. All The d and family ted. A nducted services ected. at work ee will eding a s by the s will and he vices is lan.	

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

If continuation sheet Page 22 of 22

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245365	B. WING			08/:	20/2014
NAME OF F	PROVIDER OR SUPPLIER		2		TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CERENIT	Y CARE CENTER - N	IARIAN			00 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K	000			
	Minnesota Departm time of this survey, was found in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 19 Existing Cerenity Care Cent with a partial basen constructed at 3 dif building was constr determined to be of 1969 a 2 story addi the 3rd story that w I(332) construction constructed to the r be type I(332) cons building and the ad type allowed for exis surveyed as one bu The building is fully facility has a compl smoke detection in open to the corridor automatic fire depa sleeping rooms hav detection. The facil 90 beds and had a survey. A deficiency for K-C	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care. The building was ferent times. The original ucted in 1963 and was f Type I(332) construction. In tion was constructed above as determined to be of type . In 2002 a 1 story addition was north that was determined to truction. Because the original dition(s) meet the construction sting buildings, the facility was ailding. fire sprinkler protected, The ete fire alarm system with the corridors and spaces r, that is monitored for rtment notification. Also, all ve single station smoke ity has a licensed capacity of census of 78 at the time of the p67 and annual waiver has t surveys, regarding corridors					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 10/21/2014

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245365	B. WING	;		08/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	Y CARE CENTER - M	IARIAN			200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				(¥5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From no			~~~			
1000	Continued From pa	It has been determined that	K	000			
		ne CMS S&C-06-18 letter from					
	The requirement at MET.	42 CFR, Subpart 483.70(a) is					

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

Facility ID: 00354

If continuation sheet Page 2 of 2

PRINTED: 10/21/2014



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

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

Cerenity Care Center - Marian September 4, 2014 Page 2 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,

Are Kleggse

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

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00354	B. WING		08/2	1/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CERENI	TY CARE CENTER - N	IARIAN 200 EARL SAINT PA	. STREET UL, MN 551	06		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	surveyors of this De above provider and orders are issued. completed, please s these orders and re	TS: th, 20th, and 21st, 2014, epartment's staff, visited the the following correction When corrections are sign and date, make a copy of eturn the original to the nent of Health, Division of				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 09/16/14

Electronically Signed

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If continuation sheet 1 of 19

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00354	B. WING		08/21/2014
	PROVIDER OR SUPPLIER	ARIAN 200 EAR	DDRESS, CITY, L STREET AUL, MN 551	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET
2 000	Continued From pa	age 1	2 000		
		pring, Licensing and am, P.O. Box 64900 St. Paul,			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		9/11/14
		omprehensive plan of care I personnel involved in the t.			
	by: Based on observati review, the facility o	ent is not met as evidenced ion, interview and record did not follow the individualized are for 1 of 1 resident (R125) ce.	1	Corrected	
	Findings include:				
	member (FM)-B on expressed concern	conducted with family 8/19/14, at 2:05 p.m., FM-B is related to R125's grooming to staff not cleaning ident's fingernails.			
		e plan dated as initiated aff: "Nail Care on bath day by			
	R125 was up and c wheelchair. R125's to have chipped pir observed to be soil	ion on 8/20/14, at 10:37 a.m. dressed in a tilt/recline s fingernail tips were observed nk nail polish. The nails were ed underneath with blackish sistant (NA)-B confirmed			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
		00354	B. WING		08/	08/21/2014		
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE				
ERENII	Y CARE CENTER - N	/ARIAN	L STREET AUL, MN 5510)6				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
2 565	that there was debu stated that R125 ha (8/17/14) by facility again on Thursday NA-B stated R125's cleaned during bath At 10:40 a.m. on 8/ registered nurse (R two NA's to provide at R125's fingernai were not clean. RN R125's hands were was observed to wind R125's hands, how attempt to clean un An interview condur RN-A explained that facility and the hosp provide nail care for were Sunday and T dependent resident cleaned on bath dat cares for any as ne SUGGESTED MET The director of nurs could develop and procedures to ensu- followed for all resident	were partially unpolished and ris under the fingernails. NA-B ad been bathed on Sunday staff and would be bathed (8/21/14) by a hospice aide. s nails were supposed to be in time. (20/14, clinical manager (N)-A, was observed to assist e care for R125. RN-A looked Is and acknowledged they N-A asked NA-B to make sure e washed. At 10:44 a.m. NA-B heel R125 to her room to wash rever, NA-B did not clean or iderneath R125's nails. cted on 8/21/14, at 12:39 p.m. at nursing assistants from the pice were responsible to ir R125 on her bath days which Thursday. RN-A said ts' nails should be trimmed and ty, and should be checked with eeded cleaning. THOD OF CORRECTION: sing (DON) or designee (s) implement policies and ure care plans are being dents; educate all staff. Then						
	compliance and rep Assurance Commit	systems to ensure ongoing bort the findings to the Quality ttee. R CORRECTION: Twenty-one						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00354	B. WING		08/21/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
ERENIT	TY CARE CENTER - M	IARIAN	L STREET AUL, MN 55 [.]	106	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 920	Continued From pa	ige 3	2 920		
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920		9/11/14
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,			
	by: Based on observati review, the facility o	ent is not met as evidenced ion, interview, and record lid not assure that appropriate ded for 1 of 1 resident (R125) se care.		Corrected	
	Findings include:				
	R125 was observed wheelchair while wa registered nurse (R dinner. At that time	ion on 8/18/14, at 4:45 p.m. d sitting up in a tilt/recline type aiting for dinner. At 5:04 p.m. N)-B served the resident her e, R125's nails were observed ally painted pink on the ends			
	member (FM)-B on expressed concern	r conducted with family 8/19/14, at 2:05 p.m., FM-B s related to R125's grooming to staff not cleaning ident's fingernails.			
	R125 was up and c wheelchair. R125's to have chipped pir observed to be soil	ion on 8/20/14, at 10:37 a.m. Iressed in a tilt/recline fingernail tips were observed ik nail polish. The nails were ed underneath with blackish sistant (NA)-B confirmed			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 08/21/2014	
		00354	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	TY CARE CENTER - M	IARIAN	L STREET	_		
			AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 4	2 920			
	that there was debr stated that R125 ha (8/17/14) by facility again on Thursday NA-B stated R125's cleaned during bath At 10:40 a.m. on 8/ was observed to as for R125. RN-A loc acknowledged they NA-B to make sure At 10:44 a.m. NA-E to her room to was	20/14, clinical manager RN-A, ssist two NA's to provide care oked at R125's fingernails and were not clean. RN-A asked R125's hands were washed. was observed to wheel R125 h R125's hands, however, or attempt to clean				
	12:39 p.m. RN-A exassistants from the responsible to provibath days, Sunday R125's nails should (including undernead checked with cares RN-A indicated R12 yesterday, after it with 12:55 p.m. RN-A are R125's fingernails at been cleaned adeq bath by the hospice nails had not been having a bath by the stated, " it looks like being cleaned on a	with RN-A on 8/21/14, at xplained that nursing facility and the hospice were ide R125's nail care on her and Thursday. RN-A stated d be trimmed, cleaned ath) on her bath days and for any as needed cleaning. 25's fingernails were trimmed vas brought to her attention. A nd the surveyor observed again to see whether they had juately following that morning's e NA. RN-A confirmed R125's cleaned underneath despite e hospice aide, "today." RN-A te her [R125's] nails are not regular basis underneath." ance should not be an issue for again to see with the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00354	B. WING		08/	08/21/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CERENI	TY CARE CENTER - N	VARIAN	L STREET AUL, MN 5510	06			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	age 5	2 920				
	her fingernails.						
	not triggered but sh ADL's due to end s hospice program. She is non-verbal e verbage [sic]. She	dated 1/17/14, indicated "CAA ne needs total assist with all stage Dementia. She is on All needs must be anticipated. except for non-sensical does not verbally express pair ance [sic] of pain thru facial ng away."					
	"Severely impaired and LT memory im type dementia. Re assistance with all Resistance to care difficulty following of Interventions: "Allo respond to cues/dir alteration in behavi resistance to cares assistance with toil times." Interventio	ated 3/20/12, directed staff, decision making ability d/t ST pairments R/T Alzheimer's sident relies on staff for daily decision making. s at times. Resident has cues and directions." w resident time to process and rections. Potential for for AEB (as evidenced by) s. Resident has rejected eting and getting out of bed at ns: "When resident begins to and try the task later. Do not o do the task."	1				
	R125's care plan d "Nail Care on bath	ated 3/27/12, also included: day by staff."					
	dated 2/14/13, "He Health Aid to visit 1 with ADL's (activitie	ordination in facility care plan alth East Hospice Home -2 times weekly and assist es of daily living) as needed. I be well groomed, dressed in e clothing."					
	Toenails undated, i	r for Care of Fingernails and indicated to provide nt spread of infection, and					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED	
		00354	B. WING			08/21/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CERENI	TY CARE CENTER - N	IARIAN	RL STREET PAUL, MN 5510	06			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 920	prevent injury by co appropriate. Weari and "soak nails firs procedure following a nail brush for clea necessary." SUGGESTED MET The director of nurs could develop and procedures to ensu carry out activities of care, receive the ne good grooming; ed monitoring systems compliance and rep Assurance Commit	THOD OF CORRECTION: sing (DON) or designee (s) implement policies and reresidents who are unable to of daily living, to include nail eccessary services to maintain ucate all staff. Then develop is to ensure ongoing port the findings to the Quality	0				
21100	Storage of Perishal Subp. 5. Storage of perishable food mu washable, corrosion sanitary conditions, will protect against This MN Requirem by: Based on observat review, the facility f serve food in a man development of foo potential to affect a	of perishable food. All st be stored off the floor on n-resistant shelving under and at temperatures which	21100	Corrected		9/11/14	

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If continuation sheet 7 of 19

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00354	B. WING		08/	08/21/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ERENIT	Y CARE CENTER - I	MARIAN	L STREET AUL, MN 5510	6			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
	kitchen was compl (DM). The following The meat slicer wa	55 a.m. an initial tour of the eted with the dietary manager g issues were identified: as covered with plastic wrap it was ready for use.					
	However, when the food debris was no slicer. The DM agr been cleaned thoro The large sugar an very sticky and soil There were approx saucers observed	e plastic was lifted, some dried oted on the blade of the meat eed the slicer blade had not bughly. In flour bins were noted to be led on the lids and sides. cimately 20-25 small plates and to have been put away wet teen dinner plates were					
	in the walk-in-coole as to when it had b pound bag of shree	red ham salad was observed er open for use, but not dated een opened. A half of a 5 dded mozzarella cheese was been open for use, but was					
	these issues. The DM position in the	e DM acknowledged each of DM stated she was new to the past month and was just nse of the areas that needed					
	family kitchenetter were stored in the liquid form. These directions on the la for up to 14 days a none of the shakes	5 p.m., observations in the revealed 34 nutritional shakes refrigerator, and had thawed to single serving shakes had bels indicating they were fresh fter being thawed. However, s had been dated to indicate en taken from the freezer and erator.					

	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00354	B. WING		08/	08/21/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CERENI	TY CARE CENTER - N	/ARIAN	L STREET AUL, MN 5510	06			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21100	Continued From pa	age 8	21100				
	on 8/18/14, beginni service trays were p.m. All of the bevu uncovered. The tra open three tiered c 8/18/14 at 5:30 p.m always delivered in On 8/20/14, at 9:00 smaller dining room 13 mighty shakes w thawed in the refrig shakes had been d had been thawed. During an additiona 8/20/14, at 9:30 a.m including salami, tu observed to be ope indication of when the When interviewed of DM stated the expe be dated when ope the mighty shakes, unaware that they n they had been thaw and beverages sem supposed to be cow The facility's policy Nutritional Supplem indicated nutritiona supplements which to increase palatab safety. The policy of	was observed on second floor ing at 4:30 p.m. Six room prepared for delivery at 5:30 erages and desserts were left ys were transported on an art. When interviewed on h. (NA)-A indicated trays were that manner. 0 a.m. the refrigerator in the h (kitchenette) on second floor vere observed to be stored gerator. None of these 13 lated to indicated when they al visit to the kitchen on m., packages of cold cuts irkey, and bologna were ened for use without any they had been opened. 0 8/20/14, at 9:30 a.m. the extation was that foods should oned. When interviewed about the DM stated he was required a date as to when wed. He also stated all food ved as room trays were vered during transport/delivery and procedure for their nent Program, revised 4/09, I services stocked high calorie of are stored in the refrigerator ility and to ensure product did not address the dating of nce removed from the freezer	,				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00354		B. WING		08/	21/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ERENI	TY CARE CENTER - N	MARIAN	L STREET AUL, MN 5510	16		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21100	Continued From pa	age 9	21100			
	Responsibility of N	and procedure titled ursing Service in Tray Delivery tremain covered while being the hallways.	',			
	Equipment Operati indicated the dietar developing cleanin	and procedure titled, ions and Cleaning Procedures, ry manager was responsible fo g procedures and all esponsible to follow those				
	The dietary manag develop and impler train staff, assure f served in a manne development of foo monitoring systems	THOD OF CORRECTION: er or designee (s) could ment policies and procedures, ood is stored, prepared, and r to minimize the possible od borne illness. Develop s to ensure ongoing port the findings to the Quality ttee.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21695	MN Rule 4658.141 Housekeeping, Op	5 Subp. 4 Plant eration, & Maintenance	21695			9/11/14
	provide housekeep necessary to maint comfortable interio	eeping. A nursing home must bing and maintenance services tain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,				
	This MN Requirem by:	ent is not met as evidenced				

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	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00354		B. WING		08/21/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
CERENI	TY CARE CENTER - N	ΛΔΡΙΔΝ	L STREET AUL, MN 551	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21695	Continued From pa	age 10	21695			
	review, the facility f common areas wer which had the pote their guests on the door frames were r 17 residents (R102 R97, R143, R84, R R125, R81, R98) w off of the frames, a and chairs in comm were clean and in g 21 residents and/ou Findings include: During the initial to multicolored spots from the original co and third floor.	ion, interview, and document failed to ensure resident re clean and well maintained, ntial to impact 42 residents or 2nd floor and failed to assure maintained in good repair for 2, R77, R32, R112, R178, R83, 135, R103, R117, R71, R94, whose doors had paint peeling nd failed to assure that tables non spaces on the 3rd floor good repair for approximately r their guests to use.		Corrected		
	director (ESD) on 8 following observation Significant sections	s of paint were peeling from the				
	the second floor lor R32, R112, R178, I R103, R117, R71, I Significant sections	e following residents' rooms on ng term care unit: R102, R77, R83, R97, R143, R84, R135, R94, R125, R81 and R98. s of paint were also noted to be econd floor family room and				
	near room 237. The amount of soiled sp activity/dining room five of fifteen chair	second floor, tile was cracked e carpet had a significant pots. In the second floor a, two tables were chipped and is had dried multicolored spots confirmed all findings on the				

	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	00354		B. WING		08/	21/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CERENI	TY CARE CENTER - N	MARIAN	L STREET AUL, MN 5510	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21695	second floor during carpet was cleaned carpet cleaning cor ESD also stated th thoroughly, explain multicolored spots the carpet. On 8/21 appeared the same ESD. On the 3rd floor, th special care unit ar floor transitional ca spots on them. Als area, one of two ch tear and dried spot common area had ESD confirmed find The undated Rotar Shampooing and E procedures directe Marian Center to m carpets, free of soi directions also inclu- equipment and pro carpet. However, to how frequent ca SUGGESTED MET The administrator, director or designe implement policies environment includ and door frames th clean and in good develop monitoring	age 11 g tour. The ESD stated the d by himself and a professional mpany during the week. The e carpet may not be dried ing why there were still contrasting from the color of 1/14, at 2:45 p.m. the spots e as they had during tour with ree of twelve chairs in the nd two of ten chairs in the third are unit had dried multicolored o in the third floor common hairs near the fireplace had a is on it and a couch in the dried black spots on it. The dings throughout the tour. y Scrub Carpet and Carpet Extracting policies and d staff, "It is the policy of haintain clean, hygienic I and debris at all times." The uded how to use the becedures to thoroughly clean the policy did not direct staff as rpet cleaning was required. THOD OF CORRECTION: environmental services e (s) could develop and and procedures to ensure the ling the furniture, carpeting, proughout the facility were repair; educate staff. Then g systems to ensure ongoing port the findings to the Quality		DEFICIENC	ΥΥ)	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
	00354		B. WING		08/21/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
CERENII	Y CARE CENTER - N	IARIAN	L STREET	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
21695	Continued From pa	ge 12	21695		
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		9/11/14
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a			
	by: Based on observati residents (R109, R2 ate in their rooms w dishes with plastic s rooms observed for were served desset This had the potien of the 80 residents Findings include: The evening meal w floor main dining ro p.m. Residents who were served the sa the desserts were set	vas observed in the second om (DR) on 8/19/14, at 4:30 o chose the cold beet salad lad in plastic dishes and all of served in plastic serving cups.		Corrected	
	At 5:15 p.m., room residents who ate in prepared with plast dessert and beets i 8/19/14, at 4:35 p.m was interviewed an glass bowls, otherw	trays were prepared for six in their rooms. All trays were ic silverware in addition to the in plastic serving cups. In the dietary manager (DM) d stated, "maybe we ran out of vise the food should be served then interviewed on 8/19/14 at			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	00354		B. WING		08/21/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CERENI	TY CARE CENTER - N	ΛΔRΙΔΝ	L STREET AUL, MN 5510	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21805	the kitchen does not the room trays. "We silverware for the ro maybe there wasn' On 8/20/14, at 10:3 interviewed and ind shortage of silverw was used. Although regarding use of th	age 13 assistant (NA)-A explained that of send up real silverware for e've never been given real oom trays." NA-A indicated that t enough real silverware. 30 a.m., the DM was dicated there may be a are and that was why plastic in no residents complained he plastic dishes and verified that plastic should not	t			
	The director of nurs could develop and procedures to ensu- courteous treatmer individuality by all s develop monitoring compliance and rep Assurance Commit	THOD OF CORRECTION: sing (DON) or designee (s) implement policies and ure all residents receive at and respect for their staff; educate all staff. Then systems to ensure ongoing port the findings to the Quality ttee. WR CORRECTION: Twenty-one				
22000	Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atter establish and enfor prevention plan. The assessment of the environment, and it	6.557 Subd. 14 (a)-(c) atment of Vulnerable Adults prevention plans. (a) Each he health agencies and hdant services providers, shall rce an ongoing written abuse he plan shall contain an physical plant, its ts population identifying encourage or permit abuse,	22000			9/11/14

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		00054	B. WING			
		00354			08/21/2	
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S ⁻ L STREET	TATE, ZIP CODE		
ERENIT	Y CARE CENTER - N	MARIAN .	UL, MN 5510	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
22000	Continued From pa	age 14	22000			
	to minimize the risk comply with any ru promulgated by the (b) Each facility, agency and persor providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1 abuse by other indi vulnerable adults; (other vulnerable adults; (nows that the vulner violent crime or an toward others, the plan must detail the minimize the risk the reasonably be expect facility and persons unsupervised. Undo of a vulnerable adults misconduct or phy such information fr authority or through another facility, and	including a home health care hal care attendant services velop an individual abuse each vulnerable adult eceiving services from them. tain an individualized) the person's susceptibility to ividuals, including other (2) the person's risk of abusing dults; and (3) statements of the to be taken to minimize the at person and other vulnerable poses of this paragraph, the				
inesota De	epartment of Health		6899 EV	VNF11	If continuati	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED		
	00354		B. WING		08/21/2014			
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE				
CERENI	TY CARE CENTER - N	/ARIAN	L STREET AUL, MN 55	106				
(X4) ID								
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLET DATE		
22000	Continued From pa	age 15	22000					
	This MN Requirem	ent is not met as evidenced						
	by:			Corrected				
	Based on interview and document review, the facility failed to immediately report and thoroughly		,	Corrected				
	investigate an allegation of potential mistreatment							
		(R77) reviewed for abuse						
	prohibition. Findings Include:							
		ed on 8/19/14, at 1:43 p.m.,						
		and reported how a nursing assistant (NA)-C						
		elled at him while he was taking a shower						
	several months ago. R77 explained he thought							
		o cross his arms and when						
		A-C yelled at him again, nething else. R77 stated he						
		aring and didn't think NA-C						
		m. R77 was unsure whether						
		, but stated other staff persons	;					
		ng. He recalled that the clinical						
		practical nurse (LPN)-B had						
		e next day and asked if he						
		re for him again, and R77 said ated NA-C had not cared for						
	him since the incide							
		quarterly Minimum Data Set						
	(MDS), dated 5/16/	14, identified R77 was						
		th a BIMS (brief interview for						
	,	essment score of 15, had no						
		extensive assist from staff for						
		and weight bearing support. ewed on 8/20/14, at 10:50 a.m.						
		ent with R77. LPN-B recalled						
		ed several months ago. LPN-B						
	explained that R77	had told the evening staff						
		ident and the evening nurse						
		for LPN-B, the clinical						
		th R77 the next morning. ing interviewed R77 regarding						
	epartment of Health	ing interviewed R// Tegarullig						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
				A. BUILDING:			
	00354		B. WING		08/	08/21/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	Y CARE CENTER - M	200 EAF	RL STREET				
	T CARE CENTER - I	SAINT F	PAUL, MN 5510	06			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLE DATE	
1710		,		DEFICIEN			
22000	Continued From pa	age 16	22000				
	the incident the ne	xt morning and added that					
		been interviewed. LPN-B					
		d not work with R77 again and					
		ards, R77 had moved to					
		I-B also stated NA-C had a					
		t the concern had been					
	addressed. LPN-B	verified there was no					
	documentation from	m her regarding the message					
	left by the evening	nurse, the interview with R77					
		When LPN-B was asked who					
		the incident, she stated the					
		ff for the unit had also been					
	notified at the time						
		20 a.m., the unit's social worke	r				
		ved and did not recall having					
		ing the described incident.					
		nedical record lacked any arding the incident between					
		n the reporting staff nurse or					
	from LPN-B.	in the reporting stail horse of					
		personal record included an					
		isor Conference Form" dated					
		indicated NA-C had received	a				
	verbal warning and	addressed several areas.					
		t [R77] interview, NAR (nursin	g				
		d) [NA-C] yelled at him when					
		nd what she was asking."					
		everyone with respect.					
		with dignity and compassion."					
		end annual skills fair,					
		raining." And Action:					
		will proceed to next level if					
		s." The form was signed by	1				
		The alleged employee [NA-C form and wrote: "I don't agree					
		he residents don't understand					
		them." The employee					
		as provided to survey staff by					
		n 8/21/14, at 10:50 a.m. The					
	administrator state					1	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00354	B. WING		08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CERENIT	Y CARE CENTER - N	/ARIAN	L STREET			
		SAINT P	AUL, MN 5510	6		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
22000	Continued From pa	age 17	22000			
	resident [R77] repo	orted."				
	social services (DS 8/20/14, at 1:00 p.r incident between R the incident should investigated immed previously informed then called LPN-B, additional details. I the incident betwee included informatio	sing (DON) and the director of S) were interviewed on n. When informed of the 77 and NA-C, the DON stated have been reported and diately, but denied having been d of the incident. The DON the clinical manager, for LPN-B informed the DON of en NA-C and R77 which n regarding staff personality, and a verification that R77 had				
	revised on 10/11, ic infliction of injury, u intimidation, or pun harm, pain or ment Investigation of Inc read: "All accidents allegations of abus investigated by the Director of Nursing under the heading; Resident Abuse, Ne information include Charge of Building possible abuse or r Building (COB) will Administrator, Dire Social Services or In the procedure, ""	Director of Social Services, or Designee." On page 5 "Reporting of Suspected eglect and or Crime" the d: "Staff will notify the facility immediately of any report of neglect. The Charge of immediately notify the ctor of Nursing and Director of				
	Services (DSS) imi	(DON) and Director of Social mediately upon witnessing or of mistreatment, neglect, or				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING				
	00354		B. WING		08/2	21/2014
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ERENI	TY CARE CENTER - N	/ ARIAN	L STREET AUL, MN 5510	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 18	22000			
	misappropriation o or DSS are unavail weekend, or holida Charge of Building DON or DSS. The Adult Action Plans. SUGGESTED ME The director of nur- assure that policies fully trained and the assure thorough re appropriate staff, re interviewed during residents are free f	THOD OF CORRECTION: sing and/or designee could s are followed, that staff are at audits are performed to ports have been written and esidents and family are the process to assure all				