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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HM6Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00923

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245300**
2.STATE VENDOR OR MEDICAID NO.
(L2) **253342100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - WHITE BEAR LAKE**
(L4) **1891 FLORENCE STREET**
(L5) **WHITE BEAR LAKE, MN** (L6) **55110**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2001**

6. DATE OF SURVEY **09/11/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
08/31

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

12.Total Facility Beds **138** (L18)

13.Total Certified Beds **138** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 09/21//2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/24/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/09/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245300

September 24, 2015

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1891 Florence Street
White Bear Lake, Minnesota 55110

Dear Mr. McDonald:

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 September 1, 2015 the above facility is certified for:

138 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all138 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,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 21, 2015

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1891 Florence Street
White Bear Lake, Minnesota 55110

RE: Project Number S5300025

Dear Mr. McDonald:

On August 11, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 23, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 23, 2015, effective September 1, 2015 and therefore remedies outlined in our letter to you dated August 11, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245300	A. Building B. Wing	9/11/2015

Name of Facility	Street Address, City, State, Zip Code
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **09/01/2015**
ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/01/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/20/2015**
ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/01/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/kfd	09/21/2015	15507	09/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/23/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245300	A. Building B. Wing **01 - MAIN BUILDING 01**	9/18/2015

Name of Facility	Street Address, City, State, Zip Code
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/20/2015**	ID Prefix	Correction Completed **08/20/2015**	ID Prefix	Correction Completed **08/20/2015**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **08/20/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0076		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	09/21/2015	12424	09/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/23/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245300	A. Building B. Wing 02 - 2013 ADDITION	9/18/2015

Name of Facility	Street Address, City, State, Zip Code
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	08/20/2015	ID Prefix Reg. # NFPA 101 LSC K0025	08/20/2015	ID Prefix Reg. # NFPA 101 LSC K0029	08/20/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GS/kfd	09/21/2015	12424	09/18/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 7/23/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: HM6Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00923

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245300**
2.STATE VENDOR OR MEDICAID NO.
(L2) **253342100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - WHITE BEAR LAKE**
(L4) **1891 FLORENCE STREET**
(L5) **WHITE BEAR LAKE, MN** (L6) **55110**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2001**

6. DATE OF SURVEY **07/23/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
08/31

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

12.Total Facility Beds **138** (L18)

13.Total Certified Beds **138** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	138			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lou Ann e Page HFE NE II 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 11, 2015

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1891 Florence Street
White Bear Lake, Minnesota 55110

RE: Project Number S5300025

Dear Mr. McDonald:

On July 23, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0970
Telephone: (651) 201-3792
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 1, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 1, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the

latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 23, 2015 (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 January 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an

informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 5 residents (R190) on Evergreen unit and 1 of 8 residents R38 on Cypress unit. Findings include: R190 was provided assistance with her evening meal on 7/20/15, at 4:54 p.m. Nursing assistant (NA)-F was observed standing as she fed R190 her entire meal. There were chairs available for staff to use and there was space by the table to	F 241	Staff have been re-educated on the policy/porcedure for assisting resident's at mealtime which inclludes the expectation that staff will be seated nest to a resident who requires staff assistance to eat their meal. 9/1/2015 Dining Room audits to monitor staff being seated while resident's eat their meal will be conducted by nursing personnel randomly including both meal times, 3x weekly for 4 weeks then 1x a week for 4 weeks then monthly. Nursing personnel	9/1/15

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

Electronically Signed | 08/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 sit in a chair. R38 was provided assistance to eat her continental breakfast on 7/22/15, at 9:20 a.m. NA-G was observed standing as he fed R38 her pureed doughnut and thickened beverages. R38 was one of two residents in the dining room at the time. There were ample chairs and space to sit while helping R38 to eat. NA-H and NA-I were interviewed on 7/23/15, at 3:15 p.m. They both stated it was best to sit while assisting a resident in order to be at eye level. The unit manager, registered nurse (RN)-C was interviewed on 7/23/15, at 3:22 p.m. She explained sometimes staff would stand when they needed to move from one resident to the next, but sitting at eye level was the preferred method and best for the resident. The facility policy Assistance with Meals dated September 2013, indicated, "Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: (1) Not standing over residents while assisting them with meals."	F 241	will perform immediate " in - time" training upon identification of errors or opportunities for improvement. The audit will be reviewed by the QA committee and decisions made about further audits needs. The Director of Nursing / Designee is responsible to maintain compliance. Date of Completion Sept 1, 2015	
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced	F 244		9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 2 by: Based on interview and document review, the facility failed to follow up on resident grievances for 3 of 3 residents (R107, R5, R127). Findings include: The past few months of Resident Council meeting minutes were reviewed with approval from a representative of the council. The Resident Council meeting minutes dated 4/15/15, indicated R5 had voiced a concern about staff taking a long time to answer call lights during the day and early morning hours. According to the notes, the activity director (AD) planned to have the director of nursing (DON) speak to the group about the concern at the meeting in May of 2015. The Resident Council meeting minutes dated 5/20/15, indicated the administrator and DON had been present at the meeting and and spoken to the group about plans to improve staffing. The minutes indicated the DON and administrator had stressed a desire for good service, and indicated they had identified they would ensure improved staffing soon to help respond to call lights more quickly. In addition, the minutes indicated a resident again voiced a concern of waiting for assistance and indicated a family member's concern with the lack of help during meal time. The Resident Council meeting minutes dated 6/17/15, indicated R127 and R107 had voiced concerns about having to wait "too long" for help to the bathroom. The notes indicated the AD had spoken to the residents about budget issues and the shortage of nursing assistants, and indicated the AD had told the residents the administrator was "looking at the budget now."	F 244	R107 Call light log is printed daily, reviewed with resident for one week. Call light concerns will be reviewed with resident, for 2 weeks or longer if not resolved. R107 Placed on an individualized toileting based on the bowel and bladder assessment. As previously care plan states client will continue to wear "peri pad" at night for comfort. 8/20/2015 R127 Residents needs will be anticipated and met based on assessment and change of condition, resident is care planned for Advanced/alzheimer's Due to contractures bi-laterally on hands. Clients call light has been changed to a soft paddle call cord 8/20/15 Resident council meeting added a follow - up concern form for the department managers. Each individual problem will be followed up for the person or reported to the group if a group concern arises. Any discrepancies will be reviewed at the weekly department managers meeting. Activity Director, Director of nursing or Designee are responsible to maintain compliance. Date of Completition: Sept 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 3 R107 was interviewed on 7/23/15, at 11:59 a.m. R107 stated she had waited for over an hour to have her call light answered and had experienced accidents "all the time" because she was not able to get on the toilet by herself. R107 stated she had to wear an incontinent pad, but would rather not. The resident said she had waited a long time "just yesterday." Nursing assistant (NA)-A was interviewed on 7/23/15, at 12:10 p.m. NA-A said R107 was mostly continent but wore a pad for dribbling accidents and wore a brief at night. The Care Area Assessment (CAA) dated 1/8/15, indicated R107 was incontinent of bladder and wore a peri pad at night "just in case." The care plan for R107, dated 4/8/15, indicated the resident was unable to toilet by herself related to mobility deficits. The goal was to use the toilet with staff assist and the approaches included, "peri pad at bedtime" ... "just in case. ..Own underwear during the daytime." The AD was interviewed on 7/23/15, at 1:42 p.m. She was not aware if the concern about waiting too long for help had been addressed specifically with the residents who had voiced concerns. She explained the facility did not utilize concern forms for follow up on issues, but was planning to implement such a form. In that way, concerns could be better tracked and followed up. The nurse manager registered nurse (RN)-C was interviewed on 7/23/15, at 2:05 p.m. She stated she thought the AD took care of following up on concerns. Social worker (SW)-A was interviewed at the same time. She said she was unsure about	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 4 process for following up on resident issues voiced at resident council meetings. The facility policy and procedure for resident concerns, dated 8/1/08, indicated concerns were not limited to a written grievance procedure, but could include verbal concerns. The policy indicated when a resident voiced a concern to a staff member, the staff member was to complete a concern form and forward it to the social services department.	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were within reach for use for 3 of 4 residents (R378, R38, R264), reviewed who utilized their call lights for assistance from staff. Findings include: During an interview with R378 on 7/20/15 at 6:23 p.m., R378's call light was observed wrapped around the right grab bar on the bed. R378 was seated in a recliner on the other corner of the room, on the opposite side of the bed. R378's	F 246	The Facility policy/procedure title : "Answering Call Light" was reviewed on : 9/1/2015 Staff have been re-educated on the policy/procedure for ensuring call lights are within reach for residents use. 9/1/2015 Call light audits will be conducted randomly throughout 24 hour periods by members of nursing staff and IDT. In-time training will be conducted upon	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 5 recliner was reclined back. When asked if she was able to use her call light R378 stated "yes." At 7:07 p.m. on 7/20/15, R378 was heard from the hallway calling out "help, help" as she waved her hands. R378 was still seated in the recliner in her room and the call light remained out of reach. When the surveyor asked what R378 needed, R378 stated she wanted to go to the toilet and needed help. The surveyor summoned help and nursing assistant (NA)-C responded. NA-C stated R378's son had just been at the facility visiting and it appeared he had transferred R378 without informing staff when he'd left. During this observation, NA-C verified R378 was able to use the call light. At 7:11 p.m. on 7/20/15, registered nurse (RN)-B also stated R378 was cognitively able to use the call light. RN-B stated she would have expected staff to ensure R378's call light was within reach. R378's Resident Admission Record sheet dated 7/17/15, identified the resident's diagnoses to include: nonorganic psychosis, confusion, urinary tract infection, encephalopathy, impaired renal function and acute kidney failure. R378's Individual Resident Care Plan dated 7/17/15, indicated R378 was at risk for falls and also indicated R378 was continent but required staff assistance with toileting. On 7/23/15, at 12:43 p.m. the director of nursing (DON) stated staff were to make sure resident call lights were within reach every time staff was done assisting them. R38 was observed on 7/20/15, at 6:48 p.m. to be	F 246	identification of errors, or oppotunities for improvement. The Audit results will be reviewed by the QA committee and decisions made about further audit needs. The Director of Nursing/designee is responsible to maintain compliance. Date of Completion: Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 6	F 246		

seated in her wheelchair located near the foot of her bed, with the television on. R38's eyes were closed but opened quickly when called by name. At the time of observation R38 wore a gown and pants. When approached R38 stated, "I am sitting here waiting for staff to put me to bed." The call light was observed to be out of R38's reach, coiled at the foot of the bed, approximately two feet behind and to the right of R38. When asked if she was able to use the call light when it was within reach R38 stated, "I can use the call light when I want to and it is in reach; I get tired of waiting."

On 7/20/15, at 6:50 p.m. licensed practical nurse (LPN)-D acknowledged R38's call light was not within reach. LPN-D stated, she does not always use call light, "sometimes she will use it; sometimes she will just call out. When I left her here, she had it (call light) in her lap. The aides must have moved it when they pulled the covers back."

R38's Resident Admission Record indicated her diagnoses included: paralysis agitans-Parkinson's, congestive heart failure, and bilateral lymphedema.

R38's falls Care Area Assessments (CAA) dated 5/5/15, indicated R38 was alert and able to communicate needs to staff ....Continue to incourage (sic) her to request assistance."

An undated Nursing Assistant Care Sheet indicated..."Call light in reach (sic) @ [at] all times..."

During observations on 7/20/15, at 3:55 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 7 R264's call light cord was observed on the floor, at the end of the bed. When interviewed, R264 stated that she used the call light but could not reach it. The admission assessment MDS dated 5/20/15 identified R264 cognitive status as 14/15. The facility's policy, Answering the Call Light revised October 2010, directed "5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident."	F 246		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278		9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for 1 of 3 residents (R319) who utilized an indwelling Foley catheter. Findings include: R319's hospital discharge paperwork signed by the physican and dated 5/30/15, indicated R319 had been discharged from the hospital with an indwelling Foley catheter due to urinary retention. An initial MDS dated 6/6/15, and a 30 day MDS dated 6/25/15, indicated R319 had an indwelling Foley catheter, however neither MDS included a corresponding diagnosis for the use of the Foley catheter. On 7/21/15, at 10:30 a.m. registered nurse (RN)-D was interviewed concerning the diagnosis for the use of an indwelling Foley catheter for R319. RN-D reviewed R319's record but could not determine the exact diagnosis and was unsure of the reason for the catheter. On 7/22/15, at 12:07 p.m. RN-G reviewed R319's MDS assessments. RN-G acknowledged the diagnosis of urinary retention should have been included on the initial and 30 day MDS assessments. When asked for a policy on	F 278	R319 went to Urologist on 7/23/15 catheter was changed and on 7/29 catheter was successfully removed. Residents who have a Foley Catheter have had their most recent MDS assessment reviewed for accuracy including a diagnosis for the Foley Catheter. Re-education regarding accuracy of the MDS assessment was completed with staff who are responsible for completing the MDS. Audits will be conducted prior to the MDS submission, weekly for the next 4 weeks, then monthly for 2 months, to review coding for Foley Catheters and verifing a corresponding diagnosis for the use of the Foley Catheter. The Director of Nursing / designee and the MDS Coordinator are responsible to maintain compliance. Date of completion: September 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9 completing the MDS, RN-G said the policy follows the Resident Assessment Instrument (RAI) instructions for completing all sections of the MDS. According to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 last revised October 2014, the intent of the items in the bladder section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. "Each resident who was incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible." In addition the facility was follow the Steps for Assessment which included: "1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances."	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 282	R92 was reassessed to determine	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 review, the facility failed to follow the plan of care for 1 of 3 residents (R92) reviewed who was at risk for aspiration during meals. Findings include: On 7/22/15, at 12:10 p.m. R92 was observed seated in the dining room (DR) eating and drinking independently, no staff were observed to be in the DR at that time. At 12:11 p.m. R92 took a bite of pureed consistency food. At 12:15 p.m. the registered dietician (RD) went past the DR towards the Cedar unit. At 12:16 p.m. the trained medication aide (TMA)-A was observed to walk past towards the Cypress Unit nursing station as R92 took another bite. At 12:17 p.m. the director of nursing (DON) and human resource director were both observed to pass the DR while R92 took a sip using a straw. At that time TMA-A entered the DR and sat next to R92. TMA-A asked R92 whether she wanted to eat some more and if she needed help to which R92 replied, "No." TMA-A continued to sit next to R92 and was observed assisting her. At 12:23 p.m. R92 was observed to be done eating but TMA-A stayed with her at the table and assisted R92 to drink. R92's nutritional Care Area Assessment (CAA) dated 2/26/15, indicated R92 demonstrated potential for alteration in nutrition due to weight loss, self-feeding difficulty and chewing/swallowing difficulty related to Parkinson's disease. The CAA indicated R92 received assistance and supervision at meals. R92's care plan dated 3/7/11, indicated R92 had a chewing problem related to Parkinson's. The care plan directed staff to observe R92 closely for	F 282	current need for supervision/assistance with meals on 8/20/2015 R92's care plan was reviewed to verify resident's needs and interventions are current. All Nursing Staff have been re-educated on the expectations that all staff follow the resident's care plan. Dining Room observation audits will be completed for both meals 3x weekly for 1 month, then weekly for 1 month, and monthly x1 month to ensure residents who have been assessed to require supervision are not left unattended in the Dining Room. QA team will review audits to insure compliance of dining room supervision. QA/IDT will determine if further education or staff guidance are required. The Director of Nursing/Designee is responsible for maintaining compliance Date of completion: Sept 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11 difficulty chewing, signs of choking and/or aspiration, and to provide setup help, cueing, and physical help as needed. In addition the care plan indicated R92 demonstrated potential for alteration in nutrition due to weight loss, self-feeding difficulty and chewing/swallowing difficulty related to Parkinson's disease with very slowly eating and drinking behaviors, and refusing encouragement to eat and drink. The care plan directed staff to provide setup help, frequent reminders and physical assist for meals because the resident was easily distracted during meals. R92's undated nursing assistant (NA) assignment sheet directed staff to provide "Total assist with eating ..." On 7/22/15, at 12:28 p.m. registered nurse (RN)-C stated R92 was supposed to be assisted with meals. RN-C acknowledged staff were supposed to be in the DR with R92 when R92 was eating. RN-C further stated R92 had problems with swallowing due to Parkinson's disease. At the time of the conversation NA-A also acknowledged R92 was not supposed to be left unsupervised when eating. On 7/23/15, at 12:44 p.m. the DON acknowledged R92's plan of care should have been followed and stated, "staff are supposed to be in the dining room until all residents are out. A staff person was supposed to be in the dining room when [R92] ate."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately monitor non-pressure related skin conditions for 1 of 2 residents (R239) with observed bruising. Findings include: R239 was observed on 7/20/15, at 4:11 p.m. with a large bruise on the left thumb area and two small bruises on the right arm area. R239 was interviewed and was not able to indicate how he'd gotten the bruises. When asked about the bruises, R239 was observed to rub the bruised area on the left thumb which R239 stated did not hurt. On 7/21/15, at 10:10 a.m. R239 was observed in his room seated on the recliner. R239 was still observed to have the large dark purple bruise on the left thumb. On 7/22/15, at 7:41 a.m. the large dark bruise on R239's left thumb area was still present. In addition, two small bruises on his right arm were observed to be dark purple. On 7/22/15, at 12:34 p.m. the left thumb bruise was still observed to be present. Review of R239's Progress Notes dated 7/1/15,	F 309	R239 Had an event report completed for the identified bruises. R239's family and physician were aupdated and notified about the bruises observed on the right and left thumb. R239's bruises on the thumb and right arm have healed. The care plan was updated to reflect the current resident's needs and interventions. Residents who have been identifited to have bruising have had the bruise assessed and " daily observation of the bruise till resolved" added to the eTar. The facility policy /procedure titles "Body Audit" was reviewed/revised on 8/20/15. Staff has been reeducated on the ezpectations for reporting bruising and skin impairments upon observation and routine monitoring of the bruise till it is resolved. Residents are observed for area of new bruising with AM and HS cares. Weekly skin observations are completed by a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 through 7/22/15, lacked documentation of any assessment of the bruises. After the surveyor had brought this concern to the attention of the staff, a nursing Progress Note dated 7/23/15, indicated R239 had one bruise on the left thumb and two bruises on the right arm. The note indicated the measurements and description of the bruises were as follows: - Bruise on left thumb was 4.2 centimeter (cm) by 2.0 cm dark purple in color. - Bruises on right forearm same dark purple with bruise closer proximity to elbow 1.8 cm by 1.6 cm and distal to elbow 1.0 cm by 1.5 cm. R239's care plan dated 7/3/15, indicated R239 was at risk for skin breakdown related to decreased mobility. Care plan interventions directed staff to conduct a systematic skin inspection with daily cares and weekly bath and indicated staff were to pay particular attention to the bony prominences and report any signs of skin breakdown (sore, tender, red, or broken areas). During interview with the registered nurse (RN)-A unit manager of the Transitional Care Unit (TCU) on 7/23/15 at 10:55 a.m., RN-A stated R239 was impulsive and had fallen during his stay in the TCU which had caused bruising. In addition, RN-A stated R239 had a history of Coumadin (blood thinner medication) use. RN-A verified with review of the progress notes and weekly skin risk assessments, that there had not been routine monitoring of R239's bruises. When asked what staff were expected to do when bruising was noted, RN-A stated staff were supposed to report to the nurse and that resident bruising should also be documented on the body audit forms completed weekly.	F 309	nurse and findings are documented in the progress notes. Audits of the weekly skin observation documentation, along with a visual observation of the resident will be completed 3 x weekly for 4 weeks, then weekly x 4 weeks and then monthly x1 monthto monitor for compliance for reporting and monitoring. The Director of Nursing/Designee is responsible for maintaining compliance. Date of completion: Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 At 11:05 a.m. on 7/23/15, RN-D stated when staff reported resident bruising, she would assess the bruises. RN-D also stated R239 had fallen that morning, and she thought the nurse conducting the post fall assessment should have identified the bruises and reported. At 12:45 p.m. on 7/23/15, the director of nursing (DON) stated she expected staff to report any skin changes to the nurse. The DON also stated that when the weekly body audit was conducted, the nurse was supposed to identify any changes. Although a body audit had been conducted on 7/20/15, no bruising had been identified. The facility's Body Audit policy dated 4/16/15, indicated the purpose was "To be completed for all residents for identification of alterations in skin integrity." The policy included: "7. Communication as needed to Interdisciplinary Team, Physician/NP (nurse practitioner) and Family regarding any changes in skin integrity ..."	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 323	R92 was re-assessed to determine	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15 review, the facility failed to provide the necessary supervision with a meal for 1 of 3 residents (R92) who was at risk for aspiration reviewed for accidents during a random observation. Findings include: R92's diagnoses included dysphagia, pneumonia, cerebrovascular disease, cough symptom, speech language therapy, paralysis agitans and dementia obtained from Resident Admission Record sheet dated 7/23/15. On 7/22/15, at 12:10 p.m. R92 was observed seated in the dining room (DR) eating and drinking herself and no staff was in the DR at the time nor around or close by. -At 12:11 p.m. R92 took a bite of pureed consistency food out of the plate. -At 12:15 p.m. the registered dietician (RD) went past the DR towards Cedar unit. -At 12:16 p.m. the trained medication aide (TMA)-A was observed go by went towards the Cypress Unit nursing station at the same time R92 took a bite. -At 12:17 p.m. the director of nursing (DON) and human resource director were both observed go past the DR and at the time DON was pushing a cart. At this same time R92 took a sip using a straw. -At 12:17 p.m. TMA-A came into the DR and sat next to R92 and asked her if she wanted to eat some more and if she needed help and R92 stated "No." TMA-A continued to sit next to R92 and was observed assisting her. -At 12:23 p.m. overheard TMA-A indicate to R92 she was done eating and continued to stay at the table and was observed assist R92 to drink.	F 323	current need for supervision/assistance with meals. The care plan has been reviewed to verify needs and interventions are current. The Facility policy / procedure intled "Assistance with meals was reviewed / revised. Staff have also been re-educated on the expectations for residents who have been assessed to require supervision / assistance with meals are not left unatttended. Audit results will be reviewed by the QA committee and decisions made about further audit needs. The Director of Nursing / Designee is reponsible for maintaining compliance. Date of Completion: Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 On 7/22/15, at 12:28 p.m. registered nurse (RN)-C stated R92 was supposed to be assisted with meals. RN-C acknowledged staff was supposed to be in the DR with R92 at the time. RN-C further stated R92 had problems with swallowing and had Parkinson's disease. At the time of the conversation nursing assistant (NA)-A also acknowledged R92 was not supposed to be left unsupervised when eating. On 7/23/15, at 12:44 p.m. DON stated "anybody with aspiration risk staff are supposed to be in the dining room until all residents are out. A staff person was supposed to be in the dining room or dietary staff." R92's nutritional Care Area Assessment (CAA) dated 2/26/15, indicated R92 demonstrated potential for alteration in nutrition due to weight loss, self feeding difficulty and chewing/swallowing difficulty related to Parkinson's disease. CAA indicated R92 received assistance and supervision at meals. R92's care plan dated 3/7/11, indicated R92 had a chewing problem related to Parkinsons. The care plan directed staff to observe R92 closely for difficulty chewing, signs of choking and/or aspiration and to provide setup help, cueing, and physical help as needed. In addition care plan dated 3/10/11, indicated R92 demonstrated potential for alteration in nutrition due to weight loss, self feeding difficulty and chewing/swallowing difficulty related to Parkinson's disease with very slowly eating and drink behaviors and refusing encouragement to eat and drink. Care plan directed staff to provide setup help, frequent reminders and physical assist for meals because the resident is easily	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 distracted during meals. R92's undated NA assignment sheet directed staff to provide "Total assist with eating ..." Assistance with Meals policy revised September 2013, directed: "1. Dining Room Residents: a. All residents will be encouraged to eat in the dining room. b. Facility Staff will serve resident trays and will help residents who require assistance with eating. c. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity,..."	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to ensure residents were free of significant insulin administration errors for 1 of 4 residents (R55). Findings include: R55's admission Minimum Data Set (MDS) dated 6/22/15, indicated R55 was moderately cognitively impaired and had a diagnosis of diabetes mellitus. The Physician's Order dated 6/19/15, directed	F 333	1 to 1 education provided to Rn-B regarding use of Flex Pen on 7/23/15 A medication error report was completed per facility policy on 7/23/15 R55 insulin orders were reviewed with the physician on 7/23/15 Residents with insulin orders, who have insulin administered with a flex pen, have had their orders and blood glucouse monitoring results reviewed with the	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 18 staff to administer Lantus Solostar insulin (medication used to control blood sugar) pen 100 unit/ml (3 ml) 22 units before breakfast and at hour of sleep (HS). R55 also had a sliding scale insulin order dated 7/17/15. The order read: Humalog KwikPen 100 unit/ml per sliding for blood sugar 200 to 249 give seven units, for blood sugar 250 to 299 give 10 units. During observation on 7/23/15, at 7:12 a.m. registered nurse (RN)-B was observed to prepare R55's Lantus Solostar insulin pen by wiping the top of the pen with an alcohol wipe, attach a needle and dial up 22 units. RN-B did not prime the SoloStar insulin pen. At 7:14 a.m. RN-B was observed to prepare R55's Humalog KwikPen pen by wiping the top of the pen with an alcohol wipe, attach a needle and dial up Humalog sliding scale 10 units subcutaneous (SQ) for a blood sugar of 255. RN-B did not prime the KwikPen. At 7:15 a.m. RN-B gave both injections to R55 in his left arm. When interviewed on 7/23/15, at 7:15 a.m. RN-B stated "We do not prime Flex pens." R55 did not receive the correct dose of insulin as ordered by the physician as the nurse administered 22 units of Lantus insulin instead of 24 units and neither pen was primed to ensure an accurate dose was being administered. When interviewed on 7/23/15, at 9:36 a.m. medical doctor (MD)-F stated, "I Increased insulin dosage due to recent increase in blood sugars to the 400 range when patient is normally in the 250 range." MD-F stated that not priming the insulin pens would be a nursing issue, but would not cause a significant change in R55 blood sugars. When interviewed on 7/23/15, at 1:05 p.m. the director of nursing stated they had just started	F 333	physicians. Nurses were re-educated on medication administration including how to accurately dispense and administer insulin using a flex pen on 5/21/15, 5/27/15, 7/23/15, 7/24/15, 8/20/15. The facility has added education/return demonstration on how to use a flex pen as part of new orientation for newly hired nursing staff. Audits will be completed daily x 2 weeks, then 3x weekly for 2 weeks, then weekly for 4 weeks and monthly for q month to double check accuragy with insulin administration when a flex pen is used. Review of all Nursing personel training was conducted to ensure all Nursing staff were re-educated on Flex pen administration. Orientation competencies will be obtained during new employee orientation. The Director of Nursing/designee is responsible for maintaining compliance. Date of Completion: Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 19 using insulin pens in June of 2015. She stated to prepare an insulin pen for injection a nurse would wipe the tip of the insulin pen off with an alcohol wipe, attach a needle, dial up two units of insulin, push the top of the pen to prime the insulin pen and then dial the dose that the resident is to receive. She stated that if you do not prime an insulin pen you will not give the correct dose of insulin. She stated staff was trained on using insulin pens. The package insert for Lantus SoloStar insulin by Dispensing Solutions, Inc. revised on 9/20/11, directed the provider/consumer to conduct a safety test to ensure the accuracy of dispensing the insulin to prevent under-dosing or overdosing. The instructions were as followed: "Step 3. Perform a Safety test Always perform the Safety test before each injection. Performing the safety test ensures that you get an accurate dose by: · ensuring that pen and needle work properly · removing air bubbles A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. · If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 20 · If still no insulin comes out, the needle may be blocked. Change the needle and try again. · If no insulin comes out after changing the needle, your SoloStar may be damaged. Do not use this SoloStar." The package insert for Lantus SoloStar insulin by Dispensing Solutions, Inc. revised on 9/27/12, directed the provider/consumer to prime the pen to ensure the accuracy of dispensing the insulin to prevent under-dosing or overdosing. The instructions were as followed: "Priming Humalog KwikPen - Important Notes · Prime every time. The Pen must be primed to a stream of insulin before each injection to make sure the Pen is ready to dose. · If you do not prime, you may get too much or too little insulin. Frequently Asked Questions about Priming · Why should I prime my KwikPen before each dose? 1. Ensures that the Pen is ready to dose. 2. Confirms that a stream of insulin comes out of the tip of the needle when you push the Dose Knob in. 3. Removes air that may collect in the needle or insulin cartridge during normal use. · What should I do if I cannot completely push in the Dose Knob when priming the KwikPen? 1. Attach a new needle. 2. Prime the Pen. · What should I do if I see an air bubble in the cartridge? You need to prime the Pen. Remember, do not store the Pen with the needle attached as this may cause air bubbles to collect in the insulin cartridge. A small air bubble will not affect your dose and you can continue to take your dose as usual."	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 21 The facility provided inservicing information provided by Merwin Pharmacy between 5/21/15 and 5/27/15. Topics included "How to use your Flex Pen" Instructions included "Prepare your Pen Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears." Review of attendance sheets dated 5/21/15 and 5/27/15, provided did not indicate RN-B attended inservice training on how to use a flex pen.	F 333		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain sanitary conditions for ice machines in 3 of 7 kitchenettes, for cooking and/or griddle top pans in 6 of 7 kitchenettes and an undated food item in the main kitchen to prevent the possibility for food borne illness. This had the potential to affect 133 of 135 residents who were served food and/or fluids out of all 7 kitchenettes and the main kitchen. Findings include:	F 371	All residents will be served food that is prepared withthe compliance of the Federal, State and Local authority regulations to reduce the risk of food borne illness. Corrective action includes the following: 1.) Dietary Manager updated specific cleaning assignments for taff, which are initaled and dated when completed. Cleaning assignments will be scheduled appropriately. Dietary manager will	8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22 During the kitchen and facility tour on 7/20/15, at 12:14 p.m. the following was observed and confirmed by the Culinary Services Directors (CSD-C and CSD-D). Cedar Terrace kitchenette, the resident ice machine was noted to be dripping and had a heavy lime buildup on the backsplash and drip pan. CSD-C verified it was dirty and "should be cleaned." The griddle top pan approximately 16 inches long by 8 inches wide which was found in all kitchenettes had a heavy buildup of a black substance on the cooking surface of the griddle. Rosewood kitchenette, the griddle top pan had a heavy buildup of a black substance on the cooking surface of the griddle. Gardenview kitchenette, the resident ice machine was noted to be dripping, had heavy lime buildup on the backsplash and drip pan with brown matter on the inside of the ice shoot, around the sides and corners of the drip pan and also floating in the water that was collecting in the drip pan. CSD-C stated he was not sure if a work order had been put in. Evergreen Trail kitchenette, the griddle top pan was noted to have a heavy buildup of a black substance on the cooking surface of the griddle. Transitional Care Unit (TCU) on the second floor, the resident ice machine was noted to be dripping, had a heavy lime buildup on the backsplash and drip pan as well as a buildup of brown matter on the inside of the ice shoot and on the sides and corners of the drip pan. The griddle top pan had a heavy buildup of a black	F 371	routinely complete weekly audits of cleaning lists; audits will be filed for one year. 2.)Maintenance technician was brought out to fix leaking ice machines. A schedule for deliming ice machines was regularly set up. 3.)Dietary managers held training with employees to explain information and provide staff education on infection control issues. Training included a packet employees signed. Issues included: A.) Food in coolers without dates and proper labeling. B.) Procedures for cleaning ice machines. C.) Procedures for cleaning griddles. 4.) Audits will be completed by dietary manager or assigned staff to ensure regulations are being met. 5.) Additional staff education and corrective action will be provided to ensure compliance with regulations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23	F 371		

substance on the cooking surface of the griddle. CSD-D stated an outside company was responsible for cleaning the ice machines.

During a followup kitchen and kitchenette tour on 7/22/15, at 10:00 a.m. the following was observed and verified by the Dietary Director (DD) and CSD-D.

In the main kitchen a ten pound bag (half full) of thawed frozen raspberries stored in the original cardboard box was sitting in a pan with approximately a quarter inch of red juice surrounding it. The box was not dated and had a 7/6/15 shipping date on it. DD and CSD-D stated they were unsure of how long the thawed raspberries had been in the refrigerator.

Cedar Terrace kitchenette, the resident ice machine was still dripping, a griddle top pan and a 12 inch cast iron cooking pan had a heavy buildup of a black substance on both cooking surfaces. DD stated the black substance on the pans was carbon buildup and could not come off. When DD scraped the heavy black substance she was able to remove it and agreed that it was food particle buildup on the pans.

Rosewood kitchenette, the griddle top pan the same size as noted above had a heavy buildup of a black substance on the cooking surface of the griddle.

Gardenview kitchenette, the resident ice machine was still dripping.

Evergreen Trail kitchenette, the griddle top pan and a 12 inch cast iron cooking pan had heavy buildup of a black substance on the cooking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 24 surface each pan. TCU kitchenette on the second floor, resident ice machine was still dripping, the griddle top pan and a 12 inch cast iron cooking pan had heavy buildup of a black substance on the cooking surfaces of the pans. Cyprus kitchenette, the griddle top pan had a heavy buildup of a black substance on the cooking surface of the griddle. TCU kitchenette on the first floor, the 12 inch cast iron cooking pan had heavy buildup of a black substance on the cooking surface of the pan. Review of the Storage of Food, use of leftover food policy dated 3/11, indicated that due to the potential for foodborne illness the culinary staff will be educated on safe food handling practices and storage. It further noted "all perishable food items must be in closed containers, labeled with what the food item is and the date it was opened/made." Review of the facility Days and Nights daily cleaning lists for the kitchenettes indicated to "wipe down the outside of the cupboards, drawers, stove top, ice machine/juice machine" and "clean griddle and pan, put oil on griddle." The facility's undated Cleaning Schedules policy, indicated the Culinary Department will be maintained in a clean and sanitary condition and that cleaning schedules, with all cleaning tasks listed, will be provided in the department and cleaning tasks completed in a timely and appropriate manner. Each culinary personnel are responsible to know their assigned cleaning	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 25 responsibilities and to carry them out during their work shift. When interviewed on 7/21/15, at 2:00 p.m. the DD stated that ECOLAB was responsible to clean ice machines in the kitchenettes, but dietary staff should be cleaning them daily, "it shouldn't have been that bad. We have had problems with the machines since we got them, they need to be replaced." When interviewed on 7/23/15, at 11:11 a.m. the DD stated she doesn't get the cleaning sheets back all of the time, "I need a new system." DD verified the last time ECOLAB was out to delime the ice machines was on 2/24/15.	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 411	R28 Had an oral Assessment completed	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 411	Continued From page 26 review, the facility failed to provide routine dental services for 1 of 3 residents (R28) reviewed for dental care whose dentures did not fit properly. Findings include: R28 was observed on 7/21/15 at 10:49 a.m. to have no teeth or dentures in her mouth. At that time, R28 stated she had dentures but had taken them out during her nap. When asked about her dentures, R28 stated she'd lost weight before and after her admission to the facility and although she was eating just fine now, the dentures were loose and her mouth was occassionally sore as a result. The resident's nutritional notes verified the resident's weight loss. A quarterly nutrition note dated 7/20/15, indicated R28's weight was 134.6#. A nutritional note dated 1/23/15, indicated the resident's weight had been 173.6# on 1/22/15. The resident's record identified numerous factors contributing to the weight loss. An oral assessment conducted on R28 on 1/27/15 indicated the resident had "ill-fitting dentures/appliance." The assessment summary included, "patient does not c/o (complain of) mouth problems. She says her lips and mouth stay moist as long as she has water on her table. She did say that her upper dentures bother her a little bit." R28's care plan dated 4/20/15, indicated R28 required assist of one for oral care and that R28 had upper and lower dentures, but had no difficulty eating or drinking. During an interview on 7/22/15, at 2:29 p.m. RN-F	F 411	on 7/23/2015 R28 was offered Dental Services and has an appointment scheduled for 8/26/2015 All other residents have had documentation reviewed to verify they have had an Oral Assessment completed within the past 12 months and if concerns were identified on the Oral Assessment, dental services were offered or follow-up was verified and documented. R28 has had her care plan updated to reflect current status with her dentures and reviewed at care conferences. A Clinical Comprehensive Admission Assessment will be conducted on all admissions with in 24 hours. Auditing will be conducted by clinical managers daily. The faciliy policy/procedure related to "Dental Care" was reviewed/revised. The Staff have been re-educated on the expectations related to dental care for residents. Audits will be completed on all residents during their ARD a Comprehensive Assessment x3 months to ensure residents have an Oral Assessment completeed per facility policy and that any follow - up action required is completed and documented, including offering dental services. Audit results will be reviewed by the QA committee and decisions made about	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 411	Continued From page 27 stated she was unaware of any dental issues for R28, and RN-F stated she was not sure whether R28 had seen a dentist since her admission on 1/18/15. RN-F stated, "I will call her daughter to find out." During an interview on 7/23/15, at 12:19 p.m. licensed practical nurse (LPN)-F stated she was also unaware of dental issues for R28. During an interview on 7/23/15, at 12:53 p.m. MDS coordinator (MDS)-B stated normally an oral assessment would be in Matrix (electronic computer system) before completing an MDS and if not she would notify nursing to complete it, and a dental appointment would take place if needed. MDS-B stated "something should have been done after the (1/27/15) oral assessment identified loose dentures." During another interview with MDS-B on 7/23/15 at 1:47 p.m., MDS-B verified there had been no referrals to a dentist to adjust the ill-fitting dentures for R28.	F 411	further audit needs. The Director of Nursing/designee is responsible for maintaining compliance. Date of Completion: Sept. 1, 2015	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 28 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to securely store medications, ensure appropriate labeling, and ensure outdated medications were not available for use on 3 of 5 nursing units reviewed for medication storage. Findings include: Secure Medication Storage: On 7/22/15, during an observation at 8:52 a.m. the medication cart on the Cedar unit was observed to be unlocked and unattended. The	F 431	LPN - C was immediately re-educated on the expectations to secure medications in the cart and lock the cart when unattended. A lock was added to the refrigerator in the Cedar medication room to secure medications that require refrigeration and double-locks. All medication room doors have had capacity to unlock using a push button pad have been removed. Doors now only open using a key. All Medication carts and Medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 29 key lock was observed to be fully extended in the unlocked position. The cart was located across from the nursing station. Voltaren gel (a cream for pain) for R325 was left unattended on top of the cart. When interviewed on 7/22/15 at 8:56 a.m. licensed practical nurse (LPN)-C acknowledged she had left the cart open and unattended. During a random observation on 7/23/15, at 8:02 a.m. the Cedar medication room door was observed to be unlocked. Registered nurse (RN)-C was notified of the unlocked door. A tour of the medication room was conducted with RN-C. In addition to the unlocked door, there was no lock on the medication refrigerator which contained a sealed plastic emergency kit sealed only with a numbered plastic tab. The emergency kit contained 2 vials of Lorazepam 2mg /ml and 2 vials of insulin. RN-C stated, "the medication room door should always be locked. Someone could take it (emergency kit) right out." RN-F who was working the unit stated she had just used the key, but had not checked the door to see whether it was unlocked. Review of facility policy for Storage of Medication dated 2001 (revised 2007) included: "..The facility shall store all drugs and biological's in a safe, secure, and orderly manner... facility shall not use discontinued, outdated, or deteriorated drugs ... ...Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biological's shall be locked when not in use..." Appropriate Labeling of Medications/Outdated Medication:	F 431	rooms were checked for expired medications, and medications that were not dated when opened, as required, were not dated when opened, as required were removed/destroyed on 8/20/2015. Nurses received re-education on facilities policies related to checking labels on medication, removal of expired medications, and keeping medication secure in a locked medication cart, or locked medication room on 9/1/2015. Audits will becompleted weekly x 2 months, then monthly for 1 month on all medication carts / medication rooms to ensure expired medications are removed / destroyed and all medications are labeled properly for administration. Audits will be completed 3x weekly for 4 weeks, then weekly for 4 weeks, and monthly for 1 month to observe for locked medication carts and medication rooms, as well as observing for no medications left unattended / unsecured. Audit results will be reviewed by the QA committee and decisions made about further audits need. Director of Nursing / Designee will lensure proper funcioning of locks, any malfunction if not working and will report to Maintanence Department for repairs. Date of Completion : Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 30 On 7/23/15, at 7:30 a.m. the first floor transitional care unit (TCU) medication cart #2 was observed for medication storage. A Lantus Solostar pen (a medication used to control blood sugar) was located in the top drawer of the medication cart, but lacked a prescription label; It was unable to be determined to whom the Solostar pen had been dispensed or when it had been dispensed. There were 220 out of 300 units remaining in the insulin dispense pen. A bottle of advanced stress formula plus Zinc (nutritional supplement) was found in the cart with an expiration date of 3/15. The label indicated the bottle had beens opened 1/3/14. A bottle of calcium 600 milligrams (mg) with vitamin d 400 iu (international units) was dated as opened 7/16/15. The manufacturer's expiration date was 5/15. RN-B verified that although no one was currently using these medications, the expired medications remained available for use. A Lantus Solostar pen for R55 was not dated when opened, the dispensed date was within last 28 days. On 07/23/15, at 7:35 a.m. a tour was conducted of the first floor TCU medication room with RN-B. Stored in the medication refrigerator was an undated open vial of Aplisol (tuberculin skin testing), dispensed 7/15/15 but not dated when the vial was opened. In addition, there was a bottle of Cranberry supplement that was dated as opened 8/22/14, the manufacturer's expiration date was 6/15. RN-B stated no one was currently taking the cranberry supplement, but added that the nurses should be checking medications for expiration and removing them if expired. On 7/23/15, at 7:50 a.m. a tour was conducted of the Cyprus Court medication room with with LPN-E. Stored in the medication refrigerator was	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 31 an expired vial of Aplisol. LPN-E, acknowledged the Aplisol was dated as having been opened 4/15, and was expired and available for use. A review of the manufacturer's insert for Aplisol indicated; "..Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 32 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were used during cares for 2 of 3 residents (R92, R19) reviewed for incontinence. In addition, the facility failed to ensure that clean linens were stored in a clean and sanitary manner; and failed to ensure adequate hand hygiene was performed during meal service. Findings include: During continuous observations, on 7/22/15 at 8:30 a.m. to 9:08 a.m., nursing assistant (NA)-B was observed to assist R92 with morning cares. Supplies had been set up at the bedside and, wearing gloves, NA-B proceded to perform pericare to R92. NA-B used several clean wet wipes, four times, to clean R92's bottom, which was soiled. At 8:35 a.m., NA-B informed R92 that cream was going to be applied between R92's thighs/buttocks and after NA-B finished applying the cream the excess cream was wiped off the gloves with a wash cloth and the cloth was thrown on the floor by the night stand. NA-B informed R92 that she was going to put the incontinent pad on her, along with R92's socks and pants. NA-B,	F 441	NA - B and NA - E were immediately re-educated on the facilities policy regarding washing hands and changing gloves when providing care for residents. NA - D was immediately re-educated on the expectations of hand washing, including how to manage hand washing when wearing a splint. Staff received re-education on the facility Infection Control Policy/Procedures including proper hand washing and gloving. Dining Room audits will be completed on the same schedule to ensure infection control practices are followed during resident meal service. Clean linen storage areas will be auditied on the same schedule to ensure personal items are not stored in the clean linen areas. Audits will be reviewed by QA/IDT team and determine if further education or action plans need impletation. The Director of Nursing / Designee is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 33 with the same gloves that were used to provide pericare, used another clean wet wash cloth to wipe R92's face. NA-B told R92 that she was going to remove R92's gown and after removing the gown threw it on the floor. NA-B washed and patted dry R92's underarms and attempted to apply deodorant, however R92 refused the deoderant. Still wearing the same gloves, NA-B rolled R92, in bed, towards the wall and adjusted R92's shirt. NA-B then asked NA-A for assistance to help R92 up. At 8:48 a.m., NA-B picked the linen off the floor and bagged it, opened the bottom drawer of the bedside stand to obtain a graduate cylinder to empty the urine out of R92's Foley bag and disposed of the urine in the toilet. NA-B rinsed the cylinder, dried it with paper towels and placed it in the bottom drawer of the bedside stand. Supplies that had been used earlier were put back in the other two drawers of the bedside stand. At 8:59 a.m., NA-B removed the gloves but never washed her hands. At 9:00 a.m., NA-A asked for assistance to help R92's roommate out of bed. Without washing hands, NA-B went over to help transfer the roommate, using a Hoyer lift machine. NA-B attached the lift sheet to the Hoyer hooks and with NA-A's assistance transferred R92. At 9:05 a.m., NA-B was observed to take the catheter bag off the side of the bed and put it inside a cloth bag that was attached to the side of R92's wheelchair, using bare hands. NA-B then put a sweater on R92, informed R92 that she would assist her to brush teeth and without washing hands, NA-B donned a pair of gloves, set the tooth brush up and told R92 she was going to leave the room to get another cup. NA-B removed gloves and without washing hands, left the room went to retrieve another cup from the medication cart, came back to the room, applied another pair of	F 441	reponsible for maintaining compliance. Date of Completion Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34	F 441		

gloves, brushed R92's teeth and went to the bathroom to rinse the tooth brush. NA-B removed the gloves and assisted R92 to brush her hair. When finished NA-B stated, "let's get you some breakfast" and wheeled R92 into the dining room. After NA-B had stationed R92's wheelchair, NA-B asked R92 what she wanted to drink and started walking towards the beverage cart. At this time, 9:10 a.m., NA-B was interviewed and acknowledged she had not washed her hands after removing gloves and had not changed gloves after providing R92 pericare. NA-B was asked what the facility policy was and NA-B stated "I usually do not remove my gloves until I am done and getting the linen, like I did." When asked if she was supposed to change gloves after performing pericare NA-B stated, "I guess we have not been told when."

On 7/22/15, at 9:19 a.m., registered nurse (RN)-D was interviewed and stated the NA's were supposed to change gloves and wash hands after providing pericare and before assisting another resident.

On 7/22/15, at 9:36 a.m., RN-C was interviewed regarding gloving and washing hands and explained that her expectation was that staff change gloves and wash hands, and with pericares to change gloves and wash hands before continuing.

During a continuous observation, on 7/22/15, from 7:57 a.m. to 8:30 a.m., NA-E was observed to assist R19 with morning cares. Without washing hands, NA-E put on a pair of gloves, picked up the fall mat that was on the side of R19's bed, folded it and put it away next to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35	F 441		

head of the bed. NA-E took off R19's tabs alarm, assisted her to get up on the side of the bed,and ambulated R19 to the toilet in the bathroom. NA-E took off R19's incontinent product, placed it in the trash can and assisted R19 to sit down on the toilet. NA-E covered R19's bottom half of body with her night gown, took the transfer belt off R19, filled a basin with warm water, placed two clean washcloths on the side of the wash basin, gave one wet washcloth to R19 who washed her face, then a dry towel to wipe her face,and put a clean incontinent product around the bottom of R19's legs while R19 was still sitting down on the toilet. With the same gloved hands, NA-E touched the bottom of both shoes, while taking them off R19, went to the closet, touched closet handles, got a another pair of jeans which were put on R19's legs, just below the incontinent product, put both shoes back on, touching the bottom of the shoes, and tied the laces. NA-E then took off her gloves, took off the night gown that was covering R19, put new gloves on, without washing her hands, gave another wet washcloth with soap to R19 who washed under her arms. NA-E assisted R19 to dry her underarms, put on deodorant and lotion with the same gloved hands. NA-E then put on a shirt and pearls on R19 and combed R19's hair. NA-E then went to get a toothbrush, toothpaste and dentures from the top drawer, situated next to the sink, brushed R19's top dentures with toothpaste, placed them on the right side of the sink on a clean paper towel, got another toothbrush, put paste on the brush and gave it to R19 who brushed her bottom teeth, swished with water and spit in a container NA-E was holding. NA-E's right hand was resting on the edge of the sink as she waited for R19 to finish. NA-E rinsed R19's toothbrush and put in a container. NA-E then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 36	F 441		

gave R19 her top denture who put it in her mouth. NA-E put paper towels in the trash bag, placed the transfer belt on the resident, placed the towels in a plastic bag, placed the walker in front of the resident and handed glasses to R19, who put them on. NA-E took off gloves, did not wash hands, put new gloves on, obtained a different wet washcloth and washed R19's peri-area from front to back, folded the washcloth, again washed from front to back. NA-E pulled the incontinent pad up, then R19's pants, took off gloves, did not wash hands and assisted R19 using her walker to her wheelchair situated outside the room door. NA-E hooked up the tabs alarm on the wheelchair, brought R19 out to the dayroom. NA-E then went to the pastry container situated at the nursing station, used tongs to put a muffin on a paper plate, but then went to the closet next to the nursing station to talk with another aide. After a few minutes, NA-E turned and went to the adjoining dining room, touched the refrigerator door and opened it. NA-E was interviewed at this time, 8:30 a.m., and stated she should have washed her hands after washing R19's face and will usually wash hands after taking the dirty linen out, "I know I forgot." NA-E acknowledged that she had not properly washed her hands between tasks.

During an interview on 7/22/15, at 8:45 a.m., RN-F stated hands should be washed between glove changes, before going in and before leaving a resident's room, anytime the face is touched, before you handle any food and anytime between top and bottom cares.

During an interview on 7/23/15, at 9:59 a.m., RN-C explained that staff should be washing hands and changing gloves, always between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 37	F 441		

cares such as after pericares,"I always say if in doubt, wash your hands."

During the initial tour on the Transitional Care Unit (TCU), on 7/20/15, 12:40 p.m., the clean linen door was open to the hallway. The clean linen cart was visible from the hallway and had no cover over the linens. In addition there was a personal blue green print jacket with cigarettes and lighter in the pocket hanging on the cart and a banana on top of the cart.
At 12:43 p.m. RN-B explained that the door was usually kept shut and that it was unusual to have staff personal items there, referring to the lighter and cigarettes. RN-B closed the door, however, the door did not stay shut.

During dining room observation in the Cedar dining room on 7/20/15 at 4:43 p.m., NA-D did not wash hands upon entering the dining room or before delivering plates to residents. NA-D was noted to have a right hand splint which appeared to be made of hard plastic around two fingers and a Velcro strap around the right hand.
At 5:34 p.m., NA-D was observed to push a resident's wheel chair up to the table and then passed coffee to another resident. NA-D then brought R41 her supper plate and used three fingers of the ungloved right splinted hand to prepare the ribs for R41 to eat. NA-D was observed to wash the fingers of her right hand.
At 5:43 p.m. NA-D wheeled a resident out of the dining room and upon return did not wash hands before passing food plates to residents.

At 6:10 p.m., NA-D was observed washing her hands and did remove splint. During interview, at 6:34 p.m., NA-S stated, "I am able to remove the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38 splint." On 7/22/15, at 2:05 p.m., DON stated "If a staff member has a splint on their hand I would expect them to remove it if able and wash as normal, otherwise to wear a glove to cover the splint during any cares. On 7/23/15, at 12:47 p.m., the director of nursing (DON) stated staff were supposed to do hand hygiene, change gloves between residents, after providing pericares and follow the hand hygiene facility policy. Handwashing/Hand Hygiene policy revised August 2012, directed: "5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. When coming on duty; b. When hands are visibly soiled (hand washing with soap and water); c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); d. Before and after performing any invasive procedure (e.g. fingerstick blood sampling); e. Before and after entering isolation precaution settings; f. Before and after or handling food (hand washing with soap and water); g. Before and after assisting a resident with meals; h. Before and after assisting a resident with personal care (e.g. oral care, bathing); i. Before and after handling peripheral vascular catheter and other invasive devices;	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 39 j. Before and after inserting indwelling catheters; k. Before and after changing a dressing; l. Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); m. After personal use of the toilet (hand washing with soap and water); n. Before and after assisting a resident with toileting (hand washing with soap and water); o. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile (hand washing with soap and water); p. After blowing or wiping nose; q. After contact with a resident's mucous membranes and body fluids or excretions; r. After handling soiled or used linens, dressings, bedpans, catheters and urinals; s. After handling soiled equipment or utensils; t. After performing your personal hygiene (hand washing with soap and water); u. After removing gloves or aprons; and v. After completing duty... 7. Hand hygiene is always the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing/hand hygiene..." Assistance with meals policy revised September 2013, directed: "7. All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET** **WHITE BEAR LAKE, MN 55110**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET** **WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cerenity Care Center White Bear Lake is a 2-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1957 and was determined to be of Type II(222) construction. In 1974, addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1983, another addition was constructed to the West Wing that was determined to be of Type II (222) construction. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. In 2013, a 2 story addition was constructed to the West. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET** **WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 that is monitored for automatic fire department notification. The facility has a capacity of 178 beds and had a census of 138 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the smoke barrier in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all residents, staff and visitors within the smoke compartments.	K 025	Maintenance personnel adjusted the hinges on door to achieve proper closing of door, completed 7/24/15 All fire doors will be monitored for failure of proper closing during fire drills each month.	8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET** **WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 3 Findings include: On facility tour between 09:00 AM and 02:00 PM on 07/23/2015, it was observed that the smoke barrier boors by room 1200 did not full close when tested. This deficiency was verified by Director of Environmental Service (JH) at the time of discovery.	K 025	Credible allegation of compliance 7/24/15 Maintenance director or designated person will be responsible for auditing and reporting any discrepancies¿ to the QA committee.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 09:00 AM and 02:00 PM on 07/23/2015, it was observed that vacated resident rooms are used as storage rooms and are not equipped with self closing devices at the	K 029	Maintenance staff installed door closers on room 1301, 1303. Rooms 1312, 1313, 1314, 1315, 1317, have had all items removed and doors have now been locked and maintenance has the only key to open doors, to prevent any other department from using these rooms as storage. Completed 8/11/2015 Credible allegation of compliance 8/11/15	8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET** **WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4 following locations: 1st floor rooms 1301, 1303, 1312, 1313, 1314, 1314, 1315, 1316, 1317. This deficiency was verified by the facility Director of Envirronmental Services (JH) at the time of discovery.	K 029	Maintenance Director or designated person will enter rooms quarterly to insure rooms remain unused as storage.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 9:00 AM and 2:00 PM on 07-23-2015, it was observed that: 1) The sprinkler head in the 1st floor employee breakroom was not operable due to plaster on the head. 2) The sprinkler head in the 1st floor kitchen walkin freezer was covered with ice. This deficiency was verified by Director of Environmental Service (JH) at the time of discovery.	K 062	Olsen fire and sprinkler co. will repair head on first floor employee break room completed by 9/1/15. Olsen fire and sprinkler co. repaired sprinkler head in freezer and applied proper insulator around piping to prevent any further icing up of that area ** credible allegation of compliance 9/1/15 To insure sprinkler heads and fire alarm system are in proper order maintenance director or designated person will review fire alarm and sprinkler head inspection reports semi annually and annually. Any new construction will be will be completed within fire code standards and review by maintenance director.	8/20/15
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET** **WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076 SS=D	Continued From page 5 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview,medical gas was not stored in accordance with NFPA 99, Standards for Healthcare Facilities. This deficient practice could negatively impact all residents, visitors and staff within the smoke compartment. Findings include: On facility tour between 9:00 AM and 2:00 PM on 07-23-2015, it was observed that: The Oxygen Storage room located by room 1113 had an oxygen bottle on the flor that was not secured in its holder. This deficiency was verified by Director of Environmental Service (JH) at the time of discovery.	K 076	Maintenance staff installed hook and chain to secure canisters in place. Completed 8/13/15 Nursing staff were educated on the importance and proper way to safely store O2 containers. Maintenance Director or designated person will insure O2 rooms are safely being used. O2 rooms will be monitored by safety committee monthly or more often if necessary. Credible allegation of compliance 8/13/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **02 - 2013 ADDITION** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **02 - 2013 ADDITION** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cerenity Care Center White Bear Lake is a 2-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1957 and was determined to be of Type II(222) construction. In 1974, addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1983, another addition was constructed to the West Wing that was determined to be of Type II (222) construction. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. In 2013, a 2 story addition was constructed to the West. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **02 - 2013 ADDITION** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 that is monitored for automatic fire department notification. The facility has a capacity of 178 beds and had a census of 138 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the 2-hour fire separation at the required location. corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 Findings include: On facility tour between 9:00 AM and 2:00 PM on 07/23/2015, it was observed that the 2-hour fire separation doors did not operate as required in	K 011	Maintenance personnel adjusted latch on door to achieve proper closing of door. Completed on 7/24/15 Proper fire door closer will be monitored during fire drills for proper functioning. Employees will monitor proper fire door functioning during monthly fire alarm drills and report any non-functioning doors to maintenance; maintenance will repair any	8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **02 - 2013 ADDITION** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From page 3 the following location: 1) The fire barrier door between the new and existing nursing home on the 1st floor did not open when tested for latching due to a faulty latch. This deficiency was verified by Director of Environmental Service (JH) at the time of discovery.	K 011	non- functioning doors as needed. Maintenance will do individual fire door inspections quarterly and audit for nonfunctioning doors Credible allegation of compliance 7/24/15 Maintenance director or designated staff will insure correction and monitoring to insure deficiency does not reoccur	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the smoke barrier in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all residents, staff and visitors within the smoke compartments.	K 025	Maintenance personnel adjusted the hinges on door to achieve proper closing of door, completed 7/24/2015. All fire doors will be monitored by maintenance staff for failure of proper closing during fire drills each month and	8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **02 - 2013 ADDITION** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 4 Findings include: On facility tour between 09:00 AM and 02:00 PM on 07/23/2015, it was observed that the smoke barrier boors by Speech Therapy did not full close when tested. This deficiency was verified by Director of Environmental Service (JH) at the time of discovery.	K 025	adjusted as needed. Credible allegation of compliance 7/24/15 Maintenance director or designated staff will audit quarterly to insure the correction and monitoring of door closures and to prevent the reoccurrence of this deficiency.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 09:00 AM and 02:00 PM on 07/23/2015, it was observed that: 1) The 1st floor Soiled Linen Room 118 did not self close into the frame when tested. 2) The 1st floor Utility Room 1118 did not self close into the frame when tested. This deficiency was verified by the facility Director of Envirronmental Services (JH) at the time of discovery.	K 029	Maintenance personnel adjusted door closer on room 1118 for proper closing 7/27/15 Maintenance personnel adjusted door closure on room 118 (soiled linen) for proper closure 7/27/15 Quarterly, all self-closing doors will be audited by maintenance staff to insure proper closer and functioning. Any doors that are not functioning properly will be reported to the maintenance staff for repair QA committee will review quarterly door	8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **02 - 2013 ADDITION** B. WING _____	**07/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5	K 029	closer audit Cedible allegation of compliance 7/24/15 Maintenance director or designated personnel are responsible for correction and monitoring to prevent this deficiency from reoccurring.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 11, 2015

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1891 Florence Street
White Bear Lake, Minnesota 55110

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5300025

Dear Mr. McDonald:

The above facility was surveyed on July 20, 2015 through July 23, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 20, 21, 22, and 23, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 430	MN Rule 4658.0210 Subp. 1 Room Assignments Subpart 1. Room assignments and furnishings. A nursing home must attempt to accommodate a resident's preferences on room assignments, roommates, and furnishings whenever possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were within reach for use for 3 of 4 residents (R378, R38, R264), reviewed who utilized their call lights for assistance from staff. Findings include: During an interview with R378 on 7/20/15 at 6:23 p.m., R378's call light was observed wrapped around the right grab bar on the bed. R378 was seated in a recliner on the other corner of the room, on the opposite side of the bed. R378's recliner was reclined back. When asked if she was able to use her call light R378 stated "yes." At 7:07 p.m. on 7/20/15, R378 was heard from the hallway calling out "help, help" as she waved her hands. R378 was still seated in the recliner in her room and the call light remained out of reach. When the surveyor asked what R378 needed, R378 stated she wanted to go to the toilet and needed help. The surveyor summoned help and nursing assistant (NA)-C responded.	2 430	The Facility policy/procedure title : "Answering Call Light" was reviewed on : 9/1/2015 Staff have been re-educated on the policy/procedure for ensuring call lights are within reach for residents use. 9/1/2015 Call light audits will be conducted randomly throughout 24 hour periods by members of nursing staff and IDT. In-time training will be conducted upon identification of errors, or oppotunities for improvement. The Audit results will be reviewed by the QA committee and decisions made about further audit needs. The Director of Nursing/designee is responsible to maintain compliance. Date of Completion: Sept. 1, 2015	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 430	Continued From page 3 NA-C stated R378's son had just been at the facility visiting and it appeared he had transferred R378 without informing staff when he'd left. During this observation, NA-C verified R378 was able to use the call light. At 7:11 p.m. on 7/20/15, registered nurse (RN)-B also stated R378 was cognitively able to use the call light. RN-B stated she would have expected staff to ensure R378's call light was within reach. R378's Resident Admission Record sheet dated 7/17/15, identified the resident's diagnoses to include: nonorganic psychosis, confusion, urinary tract infection, encephalopathy, impaired renal function and acute kidney failure. R378's Individual Resident Care Plan dated 7/17/15, indicated R378 was at risk for falls and also indicated R378 was continent but required staff assistance with toileting. On 7/23/15, at 12:43 p.m. the director of nursing (DON) stated staff were to make sure resident call lights were within reach every time staff was done assisting them. R38 was observed on 7/20/15, at 6:48 p.m. to be seated in her wheelchair located near the foot of her bed, with the television on. R38's eyes were closed but opened quickly when called by name. At the time of observation R38 wore a gown and pants. When approached R38 stated, "I am sitting here waiting for staff to put me to bed." The call light was observed to be out of R38's reach, coiled at the foot of the bed, approximately two feet behind and to the right of R38. When asked if she was able to use the call light when it was within reach R38 stated, "I can use the call light when I want to and it is in reach; I get tired of waiting."	2 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 430	Continued From page 4 On 7/20/15, at 6:50 p.m. licensed practical nurse (LPN)-D acknowledged R38's call light was not within reach. LPN-D stated, she does not always use call light, "sometimes she will use it; sometimes she will just call out. When I left her here, she had it (call light) in her lap. The aides must have moved it when they pulled the covers back." R38's Resident Admission Record indicated her diagnoses included: paralysis agitans-Parkinson's, congestive heart failure, and bilateral lymphedema. R38's falls Care Area Assessments (CAA) dated 5/5/15, indicated R38 was alert and able to communicate needs to staff ....Continue to incourage (sic) her to request assistance." An undated Nursing Assistant Care Sheet indicated..."Call light in reach (sic) @ [at] all times..." During observations on 7/20/15, at 3:55 p.m., R264's call light cord was observed on the floor, at the end of the bed. When interviewed, R264 stated that she used the call light but could not reach it. The admission assessment MDS dated 5/20/15 identified R264 cognitive status as 14/15. The facility's policy, Answering the Call Light revised October 2010, directed "5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee	2 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 430	Continued From page 5 could assure that policies and procedures are revised, up to date, implemented and monitored to assure resident call lights are within reach and that residents needs are met. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 430		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 3 residents (R92) reviewed who was at risk for aspiration during meals. Findings include: On 7/22/15, at 12:10 p.m. R92 was observed seated in the dining room (DR) eating and drinking independently, no staff were observed to be in the DR at that time. At 12:11 p.m. R92 took a bite of pureed consistency food. At 12:15 p.m. the registered dietician (RD) went past the DR towards the Cedar unit. At 12:16 p.m. the trained medication aide (TMA)-A was observed to walk past towards the Cypress Unit nursing station as R92 took another bite. At 12:17 p.m. the director of nursing (DON) and human resource director were both observed to pass the DR while R92	2 565	R92 was reassessed to determine current need for supervision/assistance with meals on 8/20/2015 R92's care plan was reviewed to verify resident's needs and interventions are current. All Nursing Staff have been re-educated on the expectations that all staff follow the resident's care plan. Dining Room observation audits will be completed for both meals 3x weekly for 1 month, then weekly for 1 month, and monthly x1 month to ensure residents who have been assessed to require supervision are not left unattended in the Dining Room.	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6 took a sip using a straw. At that time TMA-A entered the DR and sat next to R92. TMA-A asked R92 whether she wanted to eat some more and if she needed help to which R92 replied, "No." TMA-A continued to sit next to R92 and was observed assisting her. At 12:23 p.m. R92 was observed to be done eating but TMA-A stayed with her at the table and assisted R92 to drink. R92's nutritional Care Area Assessment (CAA) dated 2/26/15, indicated R92 demonstrated potential for alteration in nutrition due to weight loss, self-feeding difficulty and chewing/swallowing difficulty related to Parkinson's disease. The CAA indicated R92 received assistance and supervision at meals. R92's care plan dated 3/7/11, indicated R92 had a chewing problem related to Parkinson's. The care plan directed staff to observe R92 closely for difficulty chewing, signs of choking and/or aspiration, and to provide setup help, cueing, and physical help as needed. In addition the care plan indicated R92 demonstrated potential for alteration in nutrition due to weight loss, self-feeding difficulty and chewing/swallowing difficulty related to Parkinson's disease with very slowly eating and drinking behaviors, and refusing encouragement to eat and drink. The care plan directed staff to provide setup help, frequent reminders and physical assist for meals because the resident was easily distracted during meals. R92's undated nursing assistant (NA) assignment sheet directed staff to provide "Total assist with eating ..." On 7/22/15, at 12:28 p.m. registered nurse (RN)-C stated R92 was supposed to be assisted	2 565	QA team will review audits to insure compliance of dining room supervision. QA/IDT will determine if further education or staff guidance are required. The Director of Nursing/Designee is responsible for maintaining compliance Date of completion: Sept 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 7 with meals. RN-C acknowledged staff were supposed to be in the DR with R92 when R92 was eating. RN-C further stated R92 had problems with swallowing due to Parkinson's disease. At the time of the conversation NA-A also acknowledged R92 was not supposed to be left unsupervised when eating. On 7/23/15, at 12:44 p.m. the DON acknowledged R92's plan of care should have been followed and stated, "staff are supposed to be in the dining room until all residents are out. A staff person was supposed to be in the dining room when [R92] ate." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure resident care plan was followed. The director of nursing could inservice all staff to follow the resident care plan. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	2 830		9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately monitor non-pressure related skin conditions for 1 of 2 residents (R239) with observed bruising. Findings include: R239 was observed on 7/20/15, at 4:11 p.m. with a large bruise on the left thumb area and two small bruises on the right arm area. R239 was interviewed and was not able to indicate how he'd gotten the bruises. When asked about the bruises, R239 was observed to rub the bruised area on the left thumb which R239 stated did not hurt. On 7/21/15, at 10:10 a.m. R239 was observed in his room seated on the recliner. R239 was still observed to have the large dark purple bruise on the left thumb. On 7/22/15, at 7:41 a.m. the large dark bruise on R239's left thumb area was still present. In addition, two small bruises on his right arm were observed to be dark purple. On 7/22/15, at 12:34 p.m. the left thumb bruise was still observed to be present. Review of R239's Progress Notes dated 7/1/15, through 7/22/15, lacked documentation of any assessment of the bruises. After the surveyor	2 830	R239 Had an event report completed for the identified bruises. R239's family and physician were aupdated and notified about the bruises observed on the right and left thumb. R239's bruises on the thumb and right arm have healed. The care plan was updated to reflect the current resident's needs and interventions. Residents who have been identifited to have bruising have had the bruise assessed and " daily observation of the bruise till resolved" added to the eTar. The facility policy /procedure titles "Body Audit" was reviewed/revised on 8/20/15. Staff has been reeducated on the ezpectations for reporting bruising and skin impairments upon observation and routine monitoring of the bruise till it is resolved. Residents are observed for area of new bruising with AM and HS cares. Weekly skin observations are completed by a nurse and findings are documented in the progress notes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 had brought this concern to the attention of the staff, a nursing Progress Note dated 7/23/15, indicated R239 had one bruise on the left thumb and two bruises on the right arm. The note indicated the measurements and description of the bruises were as follows: - Bruise on left thumb was 4.2 centimeter (cm) by 2.0 cm dark purple in color. - Bruises on right forearm same dark purple with bruise closer proximity to elbow 1.8 cm by 1.6 cm and distal to elbow 1.0 cm by 1.5 cm. R239's care plan dated 7/3/15, indicated R239 was at risk for skin breakdown related to decreased mobility. Care plan interventions directed staff to conduct a systematic skin inspection with daily cares and weekly bath and indicated staff were to pay particular attention to the bony prominences and report any signs of skin breakdown (sore, tender, red, or broken areas). During interview with the registered nurse (RN)-A unit manager of the Transitional Care Unit (TCU) on 7/23/15 at 10:55 a.m., RN-A stated R239 was impulsive and had fallen during his stay in the TCU which had caused bruising. In addition, RN-A stated R239 had a history of Coumadin (blood thinner medication) use. RN-A verified with review of the progress notes and weekly skin risk assessments, that there had not been routine monitoring of R239's bruises. When asked what staff were expected to do when bruising was noted, RN-A stated staff were supposed to report to the nurse and that resident bruising should also be documented on the body audit forms completed weekly. At 11:05 a.m. on 7/23/15, RN-D stated when staff reported resident bruising, she would assess the	2 830	Audits of the weekly skin observation documentation, along with a visual observation of the resident will be completed 3 x weekly for 4 weeks, then weekly x 4 weeks and then monthly x1 monthto monitor for compliance for reporting and monitoring. The Director of Nursing/Designee is responsible for maintaining compliance. Date of completion: Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 bruises. RN-D also stated R239 had fallen that morning, and she thought the nurse conducting the post fall assessment should have identified the bruises and reported. At 12:45 p.m. on 7/23/15, the director of nursing (DON) stated she expected staff to report any skin changes to the nurse. The DON also stated that when the weekly body audit was conducted, the nurse was supposed to identify any changes. Although a body audit had been conducted on 7/20/15, no bruising had been identified. The facility's Body Audit policy dated 4/16/15, indicated the purpose was "To be completed for all residents for identification of alterations in skin integrity." The policy included: "7. Communication as needed to Interdisciplinary Team, Physician/NP (nurse practitioner) and Family regarding any changes in skin integrity ..." Based on observation, interview, and document review, the facility failed to provide the necessary supervision with a meal for 1 of 3 residents (R92) who was at risk for aspiration reviewed for accidents during a random observation. Findings include: R92's diagnoses included dysphagia, pneumonia, cerebrovascular disease, cough symptom, speech language therapy, paralysis agitans and dementia obtained from Resident Admission Record sheet dated 7/23/15. On 7/22/15, at 12:10 p.m. R92 was observed seated in the dining room (DR) eating and drinking herself and no staff was in the DR at the time nor around or close by. -At 12:11 p.m. R92 took a bite of pureed	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11	2 830		

consistency food out of the plate.
-At 12:15 p.m. the registered dietician (RD) went past the DR towards Cedar unit.
-At 12:16 p.m. the trained medication aide (TMA)-A was observed go by went towards the Cypress Unit nursing station at the same time R92 took a bite.
-At 12:17 p.m. the director of nursing (DON) and human resource director were both observed go past the DR and at the time DON was pushing a cart. At this same time R92 took a sip using a straw.
-At 12:17 p.m. TMA-A came into the DR and sat next to R92 and asked her if she wanted to eat some more and if she needed help and R92 stated "No." TMA-A continued to sit next to R92 and was observed assisting her.
-At 12:23 p.m. overheard TMA-A indicate to R92 she was done eating and continued to stay at the table and was observed assist R92 to drink.

On 7/22/15, at 12:28 p.m. registered nurse (RN)-C stated R92 was supposed to be assisted with meals. RN-C acknowledged staff was supposed to be in the DR with R92 at the time. RN-C further stated R92 had problems with swallowing and had Parkinson's disease. At the time of the conversation nursing assistant (NA)-A also acknowledged R92 was not supposed to be left unsupervised when eating.

On 7/23/15, at 12:44 p.m. DON stated "anybody with aspiration risk staff are supposed to be in the dining room until all residents are out. A staff person was supposed to be in the dining room or dietary staff."

R92's nutritional Care Area Assessment (CAA) dated 2/26/15, indicated R92 demonstrated potential for alteration in nutrition due to weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 loss, self feeding difficulty and chewing/swallowing difficulty related to Parkinson's disease. CAA indicated R92 received assistance and supervision at meals. R92's care plan dated 3/7/11, indicated R92 had a chewing problem related to Parkinsons. The care plan directed staff to observe R92 closely for difficulty chewing, signs of choking and/or aspiration and to provide setup help, cueing, and physical help as needed. In addition care plan dated 3/10/11, indicated R92 demonstrated potential for alteration in nutrition due to weight loss, self feeding difficulty and chewing/swallowing difficulty related to Parkinson's disease with very slowly eating and drink behaviors and refusing encouragement to eat and drink. Care plan directed staff to provide setup help, frequent reminders and physical assist for meals because the resident is easily distracted during meals. R92's undated NA assignment sheet directed staff to provide "Total assist with eating ..." Assistance with Meals policy revised September 2013, directed: "1. Dining Room Residents: a. All residents will be encouraged to eat in the dining room. b. Facility Staff will serve resident trays and will help residents who require assistance with eating. c. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity,..." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revice policies and procedures related to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 assessments, monitoring and care, and could provide staff education related to the care of residents. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain sanitary conditions for ice machines in 3 of 7 kitchenettes, for cooking and/or griddle top pans in 6 of 7 kitchenettes and an undated food item in the main kitchen to prevent the possibility for food borne illness. This had the potential to affect 133 of 135 residents who were served food and/or fluids out of all 7 kitchenettes and the main kitchen. Findings include: During the kitchen and facility tour on 7/20/15, at 12:14 p.m. the following was observed and confirmed by the Culinary Services Directors (CSD-C and CSD-D).	21015	All residents will be served food that is prepared withthe compliance of the Federal, State and Local authority regulations to reduce the risk of food borne illness. Corrective action includes the following: 1.) Dietary Manager updated specific cleaning assignments for taff, which are initaled and dated when completed. Cleaning assignments will be scheduled appropriately. Dietary manager will routinely complete weekly audits of cleaning lists; audits will be filed for one year. 2.)Maintenance technician was brought out to fix leaking ice machines. A	8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 14 Cedar Terrace kitchenette, the resident ice machine was noted to be dripping and had a heavy lime buildup on the backsplash and drip pan. CSD-C verified it was dirty and "should be cleaned." The griddle top pan approximately 16 inches long by 8 inches wide which was found in all kitchenettes had a heavy buildup of a black substance on the cooking surface of the griddle. Rosewood kitchenette, the griddle top pan had a heavy buildup of a black substance on the cooking surface of the griddle. Gardenview kitchenette, the resident ice machine was noted to be dripping, had heavy lime buildup on the backsplash and drip pan with brown matter on the inside of the ice shoot, around the sides and corners of the drip pan and also floating in the water that was collecting in the drip pan. CSD-C stated he was not sure if a work order had been put in. Evergreen Trail kitchenette, the griddle top pan was noted to have a heavy buildup of a black substance on the cooking surface of the griddle. Transitional Care Unit (TCU) on the second floor, the resident ice machine was noted to be dripping, had a heavy lime buildup on the backsplash and drip pan as well as a buildup of brown matter on the inside of the ice shoot and on the sides and corners of the drip pan. The griddle top pan had a heavy buildup of a black substance on the cooking surface of the griddle. CSD-D stated an outside company was responsible for cleaning the ice machines. During a followup kitchen and kitchenette tour on 7/22/15, at 10:00 a.m. the following was observed and verified by the Dietary Director (DD) and	21015	schedule for deliming ice machines was regularly set up. 3.)Dietary managers held training with employees to explain information and provide staff education on infection control issues. Training included a packet employees signed. Issues included: A.) Food in coolers without dates and proper labeling. B.) Procedures for cleaning ice machines. C.) Procedures for cleaning griddles. 4.) Audits will be completed by dietary manager or assigned staff to ensure regulations are being met. 5.) Additional staff education and corrective action will be provided to ensure compliance with regulations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 15 CSD-D. In the main kitchen a ten pound bag (half full) of thawed frozen raspberries stored in the original cardboard box was sitting in a pan with approximately a quarter inch of red juice surrounding it. The box was not dated and had a 7/6/15 shipping date on it. DD and CSD-D stated they were unsure of how long the thawed raspberries had been in the refrigerator. Cedar Terrace kitchenette, the resident ice machine was still dripping, a griddle top pan and a 12 inch cast iron cooking pan had a heavy buildup of a black substance on both cooking surfaces. DD stated the black substance on the pans was carbon buildup and could not come off. When DD scraped the heavy black substance she was able to remove it and agreed that it was food particle buildup on the pans. Rosewood kitchenette, the griddle top pan the same size as noted above had a heavy buildup of a black substance on the cooking surface of the griddle. Gardenview kitchenette, the resident ice machine was still dripping. Evergreen Trail kitchenette, the griddle top pan and a 12 inch cast iron cooking pan had heavy buildup of a black substance on the cooking surface each pan. TCU kitchenette on the second floor, resident ice machine was still dripping, the griddle top pan and a 12 inch cast iron cooking pan had heavy buildup of a black substance on the cooking surfaces of the pans.	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 16 Cyprus kitchenette, the griddle top pan had a heavy buildup of a black substance on the cooking surface of the griddle. TCU kitchenette on the first floor, the 12 inch cast iron cooking pan had heavy buildup of a black substance on the cooking surface of the pan. Review of the Storage of Food, use of leftover food policy dated 3/11, indicated that due to the potential for foodborne illness the culinary staff will be educated on safe food handling practices and storage. It further noted "all perishable food items must be in closed containers, labeled with what the food item is and the date it was opened/made." Review of the facility Days and Nights daily cleaning lists for the kitchenettes indicated to "wipe down the outside of the cupboards, drawers, stove top, ice machine/juice machine" and "clean griddle and pan, put oil on griddle." The facility's undated Cleaning Schedules policy, indicated the Culinary Department will be maintained in a clean and sanitary condition and that cleaning schedules, with all cleaning tasks listed, will be provided in the department and cleaning tasks completed in a timely and appropriate manner. Each culinary personnel are responsible to know their assigned cleaning responsibilities and to carry them out during their work shift. When interviewed on 7/21/15, at 2:00 p.m. the DD stated that ECOLAB was responsible to clean ice machines in the kitchenettes, but dietary staff should be cleaning them daily, "it shouldn't have been that bad. We have had problems with the machines since we got them, they need to be	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 17 replaced." When interviewed on 7/23/15, at 11:11 a.m. the DD stated she doesn't get the cleaning sheets back all of the time, "I need a new system." DD verified the last time ECOLAB was out to delime the ice machines was on 2/24/15. SUGGESTED METHOD OF CORRECTION: The administrator and dietary manager could educate staff related to dietary sanitation and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21015		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine dental services for 1 of 3 residents (R28) reviewed for dental care whose dentures did not fit properly. Findings include:	21325	R28 Had an oral Assessment completed on 7/23/2015 R28 was offered Dental Services and has an appointment scheduled for 8/26/2015	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 18 R28 was observed on 7/21/15 at 10:49 a.m. to have no teeth or dentures in her mouth. At that time, R28 stated she had dentures but had taken them out during her nap. When asked about her dentures, R28 stated she'd lost weight before and after her admission to the facility and although she was eating just fine now, the dentures were loose and her mouth was occassionally sore as a result. The resident's nutritional notes verified the resident's weight loss. A quarterly nutrition note dated 7/20/15, indicated R28's weight was 134.6#. A nutritional note dated 1/23/15, indicated the resident's weight had been 173.6# on 1/22/15. The resident's record identified numerous factors contributing to the weight loss. An oral assessment conducted on R28 on 1/27/15 indicated the resident had "ill-fitting dentures/appliance." The assessment summary included, "patient does not c/o (complain of) mouth problems. She says her lips and mouth stay moist as long as she has water on her table. She did say that her upper dentures bother her a little bit." R28's care plan dated 4/20/15, indicated R28 required assist of one for oral care and that R28 had upper and lower dentures, but had no difficulty eating or drinking. During an interview on 7/22/15, at 2:29 p.m. RN-F stated she was unaware of any dental issues for R28, and RN-F stated she was not sure whether R28 had seen a dentist since her admission on 1/18/15. RN-F stated, "I will call her daughter to find out."	21325	All other residents have had documentation reviewed to verify they have had an Oral Assessment completed within the past 12 months and if concerns were identified on the Oral Assessment, dental services were offered or follow-up was verified and documented. R28 has had her care plan updated to reflect current status with her dentures and reviewed at care conferences. A Clinical Comprehensive Admission Assessment will be conducted on all admissions with in 24 hours. Auditing will be conducted by clinical managers daily. The faciliy policy/procedure related to "Dental Care" was reviewed/revised. The Staff have been re-educated on the expectations related to dental care for residents. Audits will be completed on all residents during their ARD a Comprehensive Assessment x3 months to ensure residents have an Oral Assessment completeed per facility policy and that any follow - up action required is completed and documented, including offering dental services. Audit results will be reviewed by the QA committee and decisions made about further audit needs. The Director of Nursing/designee is responsible for maintaining compliance. Date of Completion: Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 19 During an interview on 7/23/15, at 12:19 p.m. licensed practical nurse (LPN)-F stated she was also unaware of dental issues for R28. During an interview on 7/23/15, at 12:53 p.m. MDS coordinator (MDS)-B stated normally an oral assessment would be in Matrix (electronic computer system) before completing an MDS and if not she would notify nursing to complete it, and a dental appointment would take place if needed. MDS-B stated "something should have been done after the (1/27/15) oral assessment identified loose dentures." During another interview with MDS-B on 7/23/15 at 1:47 p.m., MDS-B verified there had been no referrals to a dentist to adjust the ill-fitting dentures for R28. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to dental care for residents and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents;	21390		9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 20 B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were used during cares for 2 of 3 residents (R92, R19) reviewed for incontinence. In addition, the facility failed to ensure that clean linens were stored in a clean and sanitary manner; and failed to ensure adequate hand hygiene was performed during meal service. Findings include: During continuous observations, on 7/22/15 at 8:30 a.m. to 9:08 a.m., nursing assistant (NA)-B	21390	NA - B and NA - E were immediately re-educated on the facilities policy regarding washing hands and changing gloves when providing care for residents. NA - D was immediately re-educated on the expectations of hand washing, including how to manage hand washing when wearing a splint. Staff received re-education on the facility Infection Control Policy/Procedures including proper hand washing and gloving. Dining Room audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 21 was observed to assist R92 with morning cares. Supplies had been set up at the bedside and, wearing gloves, NA-B proceded to perform pericare to R92. NA-B used several clean wet wipes, four times, to clean R92's bottom, which was soiled. At 8:35 a.m., NA-B informed R92 that cream was going to be applied between R92's thighs/buttocks and after NA-B finished applying the cream the excess cream was wiped off the gloves with a wash cloth and the cloth was thrown on the floor by the night stand. NA-B informed R92 that she was going to put the incontinent pad on her, along with R92's socks and pants. NA-B, with the same gloves that were used to provide pericare, used another clean wet wash cloth to wipe R92's face. NA-B told R92 that she was going to remove R92's gown and after removing the gown threw it on the floor. NA-B washed and patted dry R92's underarms and attempted to apply deodorant, however R92 refused the deoderant. Still wearing the same gloves, NA-B rolled R92, in bed, towards the wall and adjusted R92's shirt. NA-B then asked NA-A for assistance to help R92 up. At 8:48 a.m., NA-B picked the linen off the floor and bagged it, opened the bottom drawer of the bedside stand to obtain a graduate cylinder to empty the urine out of R92's Foley bag and disposed of the urine in the toilet. NA-B rinsed the cylinder, dried it with paper towels and placed it in the bottom drawer of the bedside stand. Supplies that had been used earlier were put back in the other two drawers of the bedside stand. At 8:59 a.m., NA-B removed the gloves but never washed her hands. At 9:00 a.m., NA-A asked for assistance to help R92's roommate out of bed. Without washing hands, NA-B went over to help transfer the roommate, using a Hoyer lift machine. NA-B attached the lift sheet to the Hoyer hooks and with NA-A's assistance transferred R92. At 9:05 a.m., NA-B	21390	completed on the same schedule to ensure infection control practices are followed during resident meal service. Clean linen storage areas will be auditied on the same schedule to ensure personal items are not stored in the clean linen areas. Audits will be reviewed by QA/IDT team and determine if further education or action plans need impletation. The Director of Nursing / Designee is reponsible for maintaining compliance. Date of Completion Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 22	21390		

was observed to take the catheter bag off the side of the bed and put it inside a cloth bag that was attached to the side of R92's wheelchair, using bare hands. NA-B then put a sweater on R92, informed R92 that she would assist her to brush teeth and without washing hands, NA-B donned a pair of gloves, set the tooth brush up and told R92 she was going to leave the room to get another cup. NA-B removed gloves and without washing hands, left the room went to retrieve another cup from the medication cart, came back to the room, applied another pair of gloves, brushed R92's teeth and went to the bathroom to rinse the tooth brush. NA-B removed the gloves and assisted R92 to brush her hair. When finished NA-B stated, "let's get you some breakfast" and wheeled R92 into the dining room. After NA-B had stationed R92's wheelchair, NA-B asked R92 what she wanted to drink and started walking towards the beverage cart. At this time, 9:10 a.m., NA-B was interviewed and acknowledged she had not washed her hands after removing gloves and had not changed gloves after providing R92 pericare. NA-B was asked what the facility policy was and NA-B stated "I usually do not remove my gloves until I am done and getting the linen, like I did." When asked if she was supposed to change gloves after performing pericare NA-B stated, "I guess we have not been told when."

On 7/22/15, at 9:19 a.m., registered nurse (RN)-D was interviewed and stated the NA's were supposed to change gloves and wash hands after providing pericare and before assisting another resident.

On 7/22/15, at 9:36 a.m., RN-C was interviewed regarding gloving and washing hands and explained that her expectation was that staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 23 change gloves and wash hands, and with pericares to change gloves and wash hands before continuing. During a continuous observation, on 7/22/15, from 7:57 a.m. to 8:30 a.m., NA-E was observed to assist R19 with morning cares. Without washing hands, NA-E put on a pair of gloves, picked up the fall mat that was on the side of R19's bed, folded it and put it away next to the head of the bed. NA-E took off R19's tabs alarm, assisted her to get up on the side of the bed,and ambulated R19 to the toilet in the bathroom. NA-E took off R19's incontinent product, placed it in the trash can and assisted R19 to sit down on the toilet. NA-E covered R19's bottom half of body with her night gown, took the transfer belt off R19, filled a basin with warm water, placed two clean washcloths on the side of the wash basin, gave one wet washcloth to R19 who washed her face, then a dry towel to wipe her face,and put a clean incontinent product around the bottom of R19's legs while R19 was still sitting down on the toilet. With the same gloved hands, NA-E touched the bottom of both shoes, while taking them off R19, went to the closet, touched closet handles, got a another pair of jeans which were put on R19's legs, just below the incontinent product, put both shoes back on, touching the bottom of the shoes, and tied the laces. NA-E then took off her gloves, took off the night gown that was covering R19, put new gloves on, without washing her hands, gave another wet washcloth with soap to R19 who washed under her arms. NA-E assisted R19 to dry her underarms, put on deodorant and lotion with the same gloved hands. NA-E then put on a shirt and pearls on R19 and combed R19's hair. NA-E then	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 24 went to get a toothbrush, toothpaste and dentures from the top drawer, situated next to the sink, brushed R19's top dentures with toothpaste, placed them on the right side of the sink on a clean paper towel, got another toothbrush, put paste on the brush and gave it to R19 who brushed her bottom teeth, swished with water and spit in a container NA-E was holding. NA-E's right hand was resting on the edge of the sink as she waited for R19 to finish. NA-E rinsed R19's toothbrush and put in a container. NA-E then gave R19 her top denture who put it in her mouth. NA-E put paper towels in the trash bag, placed the transfer belt on the resident, placed the towels in a plastic bag, placed the walker in front of the resident and handed glasses to R19, who put them on. NA-E took off gloves, did not wash hands, put new gloves on, obtained a different wet washcloth and washed R19's peri-area from front to back, folded the washcloth, again washed from front to back. NA-E pulled the incontinent pad up, then R19's pants, took off gloves, did not wash hands and assisted R19 using her walker to her wheelchair situated outside the room door. NA-E hooked up the tabs alarm on the wheelchair, brought R19 out to the dayroom. NA-E then went to the pastry container situated at the nursing station, used tongs to put a muffin on a paper plate, but then went to the closet next to the nursing station to talk with another aide. After a few minutes, NA-E turned and went to the adjoining dining room, touched the refrigerator door and opened it. NA-E was interviewed at this time, 8:30 a.m., and stated she should have washed her hands after washing R19's face and will usually wash hands after taking the dirty linen out, "I know I forgot." NA-E acknowledged that she had not properly washed her hands between tasks.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 25 During an interview on 7/22/15, at 8:45 a.m., RN-F stated hands should be washed between glove changes, before going in and before leaving a resident's room, anytime the face is touched, before you handle any food and anytime between top and bottom cares. During an interview on 7/23/15, at 9:59 a.m., RN-C explained that staff should be washing hands and changing gloves, always between cares such as after pericares,"I always say if in doubt, wash your hands." During the initial tour on the Transitional Care Unit (TCU), on 7/20/15, 12:40 p.m., the clean linen door was open to the hallway. The clean linen cart was visible from the hallway and had no cover over the linens. In addition there was a personal blue green print jacket with cigarettes and lighter in the pocket hanging on the cart and a banana on top of the cart. At 12:43 p.m. RN-B explained that the door was usually kept shut and that it was unusual to have staff personal items there, referring to the lighter and cigarettes. RN-B closed the door, however, the door did not stay shut. During dining room observation in the Cedar dining room on 7/20/15 at 4:43 p.m., NA-D did not wash hands upon entering the dining room or before delivering plates to residents. NA-D was noted to have a right hand splint which appeared to be made of hard plastic around two fingers and a Velcro strap around the right hand. At 5:34 p.m., NA-D was observed to push a resident's wheel chair up to the table and then passed coffee to another resident. NA-D then brought R41 her supper plate and used three	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 26 fingers of the ungloved right splinted hand to prepare the ribs for R41 to eat. NA-D was observed to wash the fingers of her right hand. At 5:43 p.m. NA-D wheeled a resident out of the dining room and upon return did not wash hands before passing food plates to residents. At 6:10 p.m., NA-D was observed washing her hands and did remove splint. During interview, at 6:34 p.m., NA-S stated, "I am able to remove the splint." On 7/22/15, at 2:05 p.m., DON stated "If a staff member has a splint on their hand I would expect them to remove it if able and wash as normal, otherwise to wear a glove to cover the splint during any cares. On 7/23/15, at 12:47 p.m., the director of nursing (DON) stated staff were supposed to do hand hygiene, change gloves between residents, after providing pericares and follow the hand hygiene facility policy. Handwashing/Hand Hygiene policy revised August 2012, directed: "5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. When coming on duty; b. When hands are visibly soiled (hand washing with soap and water); c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); d. Before and after performing any invasive procedure (e.g. fingerstick blood sampling); e. Before and after entering isolation	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 27 precaution settings; f. Before and after or handling food (hand washing with soap and water); g. Before and after assisting a resident with meals; h. Before and after assisting a resident with personal care (e.g. oral care, bathing); i. Before and after handling peripheral vascular catheter and other invasive devices; j. Before and after inserting indwelling catheters; k. Before and after changing a dressing; l. Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); m. After personal use of the toilet (hand washing with soap and water); n. Before and after assisting a resident with toileting (hand washing with soap and water); o. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile (hand washing with soap and water); p. After blowing or wiping nose; q. After contact with a resident's mucous membranes and body fluids or excretions; r. After handling soiled or used linens, dressings, bedpans, catheters and urinals; s. After handling soiled equipment or utensils; t. After performing your personal hygiene (hand washing with soap and water); u. After removing gloves or aprons; and v. After completing duty... 7. Hand hygiene is always the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing/hand hygiene..."	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 28 Assistance with meals policy revised September 2013, directed: "7. All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that infection control policies and procedures are up to date and that staff are trained, monitored and evaluated to assure good hand washing and gloving is performed sufficiently when caring for residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication	21545		9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 29 error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interviews and document review, the facility failed to ensure residents were free of significant insulin administration errors for 1 of 4 residents (R55). Findings include: R55's admission Minimum Data Set (MDS) dated	21545	1 to 1 education provided to Rn-B regarding use of Flex Pen on 7/23/15 A medication error report was completed per facility policy on 7/23/15 R55 insulin orders were reviewed with the physician on 7/23/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 30 6/22/15, indicated R55 was moderately cognitively impaired and had a diagnosis of diabetes mellitus. The Physician's Order dated 6/19/15, directed staff to administer Lantus Solostar insulin (medication used to control blood sugar) pen 100 unit/ml (3 ml) 22 units before breakfast and at hour of sleep (HS). R55 also had a sliding scale insulin order dated 7/17/15. The order read: Humalog KwikPen 100 unit/ml per sliding for blood sugar 200 to 249 give seven units, for blood sugar 250 to 299 give 10 units. During observation on 7/23/15, at 7:12 a.m. registered nurse (RN)-B was observed to prepare R55's Lantus Solostar insulin pen by wiping the top of the pen with an alcohol wipe, attach a needle and dial up 22 units. RN-B did not prime the SoloStar insulin pen. At 7:14 a.m. RN-B was observed to prepare R55's Humalog KwikPen pen by wiping the top of the pen with an alcohol wipe, attach a needle and dial up Humalog sliding scale 10 units subcutaneous (SQ) for a blood sugar of 255. RN-B did not prime the KwikPen. At 7:15 a.m. RN-B gave both injections to R55 in his left arm. When interviewed on 7/23/15, at 7:15 a.m. RN-B stated "We do not prime Flex pens." R55 did not receive the correct dose of insulin as ordered by the physician as the nurse administered 22 units of Lantus insulin instead of 24 units and neither pen was primed to ensure an accurate dose was being administered. When interviewed on 7/23/15, at 9:36 a.m. medical doctor (MD)-F stated, "I Increased insulin dosage due to recent increase in blood sugars to the 400 range when patient is normally in the 250 range." MD-F stated that not priming the insulin pens would be a nursing issue, but would not	21545	Residents with insulin orders, who have insulin administered with a flex pen, have had their orders and blood glucouse monitoring results reviewed with the physicians. Nurses were re-educated on medication administration including how to accurately dispense and administer insulin using a flex pen on 5/21/15, 5/27/15, 7/23/15, 7/24/15. The facility has added education/return demonstration on how to use a flex pen as part of new orientation for newly hired nursing staff. Audits will be completed daily x 2 weeks, then 3x weekly for 2 weeks, then weekly for 4 weeks and monthly for q month to double check accuragy with insulin administration when a flex pen is used. Review of all Nursing personel training was conducted to ensure all Nursing staff were re-educated on Flex pen administration. Orientation competencies will be obtained during new employee orientation. The Director of Nursing/designee is responsible for maintaining compliance. Date of Completion: Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 31 cause a significant change in R55 blood sugars. When interviewed on 7/23/15, at 1:05 p.m. the director of nursing stated they had just started using insulin pens in June of 2015. She stated to prepare an insulin pen for injection a nurse would wipe the tip of the insulin pen off with an alcohol wipe, attach a needle, dial up two units of insulin, push the top of the pen to prime the insulin pen and then dial the dose that the resident is to receive. She stated that if you do not prime an insulin pen you will not give the correct dose of insulin. She stated staff was trained on using insulin pens. The package insert for Lantus SoloStar insulin by Dispensing Solutions, Inc. revised on 9/20/11, directed the provider/consumer to conduct a safety test to ensure the accuracy of dispensing the insulin to prevent under-dosing or overdosing. The instructions were as followed: "Step 3. Perform a Safety test Always perform the Safety test before each injection. Performing the safety test ensures that you get an accurate dose by: · ensuring that pen and needle work properly · removing air bubbles A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen.	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 32 · If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. · If still no insulin comes out, the needle may be blocked. Change the needle and try again. · If no insulin comes out after changing the needle, your SoloStar may be damaged. Do not use this SoloStar." The package insert for Lantus SoloStar insulin by Dispensing Solutions, Inc. revised on 9/27/12, directed the provider/consumer to prime the pen to ensure the accuracy of dispensing the insulin to prevent under-dosing or overdosing. The instructions were as followed: "Priming Humalog KwikPen - Important Notes · Prime every time. The Pen must be primed to a stream of insulin before each injection to make sure the Pen is ready to dose. · If you do not prime, you may get too much or too little insulin. Frequently Asked Questions about Priming · Why should I prime my KwikPen before each dose? 1. Ensures that the Pen is ready to dose. 2. Confirms that a stream of insulin comes out of the tip of the needle when you push the Dose Knob in. 3. Removes air that may collect in the needle or insulin cartridge during normal use. · What should I do if I cannot completely push in the Dose Knob when priming the KwikPen? 1. Attach a new needle. 2. Prime the Pen. · What should I do if I see an air bubble in the cartridge? You need to prime the Pen. Remember, do not store the Pen with the needle attached as this may cause air bubbles to collect in the insulin cartridge. A small air bubble will not affect your dose and you can continue to take	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 33 your dose as usual." The facility provided inservicing information provided by Merwin Pharmacy between 5/21/15 and 5/27/15. Topics included "How to use your Flex Pen" Instructions included "Prepare your Pen Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears." Review of attendance sheets dated 5/21/15 and 5/27/15, provided did not indicate RN-B attended inservice training on how to use a flex pen. SUGGESTED METHOD OF CORRECTION: The facility could review their policies on medication administration, provide education on medication administration, and implement an auditing system to ensure safe medication administration and ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21545		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to securely store medications on 1 of 5 nursing units reviewed for medication storage.	21610	LPN - C was immediately re-educated on the expectations to secure medications in the cart and lock the cart when unattended.	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 34 Findings include: On 7/22/15, during an observation at 8:52 a.m. the medication cart on the Cedar unit was observed to be unlocked and unattended. The key lock was observed to be fully extended in the unlocked position. The cart was located across from the nursing station. Voltaren gel (a cream for pain) for R325 was left unattended on top of the cart. When interviewed on 7/22/15 at 8:56 a.m. licensed practical nurse (LPN)-C acknowledged she had left the cart open and unattended. During a random observation on 7/23/15, at 8:02 a.m. the Cedar medication room door was observed to be unlocked. Registered nurse (RN)-C was notified of the unlocked door. A tour of the medication room was conducted with RN-C. In addition to the unlocked door, there was no lock on the medication refrigerator which contained a sealed plastic emergency kit sealed only with a numbered plastic tab. The emergency kit contained 2 vials of Lorazepam 2mg /ml and 2 vials of insulin. RN-C stated, "the medication room door should always be locked. Someone could take it (emergency kit) right out." RN-F who was working the unit stated she had just used the key, but had not checked the door to see whether it was unlocked. Review of facility policy for Storage of Medication dated 2001 (revised 2007) included: "..The facility shall store all drugs and biological's in a safe, secure, and orderly manner... facility shall not use discontinued, outdated, or deteriorated drugs ... ...Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biological's shall be locked when not in use..."	21610	A lock was added to the refrigerator in the Cedar medication room to secure medications that require refrigeration and double-locks. All medication room doors have had capacity to unlock using a push button pad have been removed. Doors now only open using a key. All Medication carts and Medication rooms were checked for expired medications, and medications that were not dated when opened, as required, were not dated when opened, as required were removed/destroyed on 8/20/2015. Nurses received re-education on facilities policies related to checking labels on medication, removal of expired medications, and keeping medication secure in a locked medication cart, or locked medication room on 9/1/2015. Audits will becompleted weekly x 2 months, then monthly for 1 month on all medication carts / medication rooms to ensure expired medications are removed / destroyed and all medications are labeled properly for administration. Audits will be completed 3x weekly for 4 weeks, then weekly for 4 weeks, and monthly for 1 month to observe for locked medication carts and medication rooms, as well as observing for no medications left unattended / unsecured. Audit results will be reviewed by the QA committee and decisions made about further audits need.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 35 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610	Director of Nursing / Designee will lensure proper funcioning of locks, any malfunction if not working and will report to Maintanence Department for repairs. Date of Completion : Sept. 1, 2015	
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were appropriately labeled, and failed to ensure outdated medications were not available for use on 2 of 5 nursing units reviewed for medication storage. Findings include: On 7/23/15, at 7:30 a.m. the first floor transitional care unit (TCU) medication cart #2 was observed for medication storage. A Lantus Solostar pen (a medication used to control blood sugar) was located in the top drawer of the medication cart, but lacked a prescription label; It was unable to be determined to whom the Solostar pen had	21620	LPN - C was immediately re-educated on the expectations to secure medications in the cart and lock the cart when unattended. A lock was added to the refrigerator in the Cedar medication room to secure medications that require refrigeration and double-locks. All medication room doors have had capacity to unlock using a push button pad have been removed. Doors now only open using a key. All Medication carts and Medication rooms were checked for expired medications, and medications that were not dated when	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 36 been dispensed or when it had been dispensed. There were 220 out of 300 units remaining in the insulin dispense pen. A bottle of advanced stress formula plus Zinc (nutritional supplement) was found in the cart with an expiration date of 3/15. The label indicated the bottle had beens opened 1/3/14. A bottle of calcium 600 milligrams (mg) with vitamin d 400 iu (international units) was dated as opened 7/16/15. The manufacturer's expiration date was 5/15. RN-B verified that although no one was currently using these medications, the expired medications remained available for use. A Lantus Solostar pen for R55 was not dated when opened, the dispensed date was within last 28 days. On 07/23/15, at 7:35 a.m. a tour was conducted of the first floor TCU medication room with RN-B. Stored in the medication refrigerator was an undated open vial of Aplisol (tuberculin skin testing), dispensed 7/15/15 but not dated when the vial was opened. In addition, there was a bottle of Cranberry supplement that was dated as opened 8/22/14, the manufacturer's expiration date was 6/15. RN-B stated no one was currently taking the cranberry supplement, but added that the nurses should be checking medications for expiration and removing them if expired. On 7/23/15, at 7:50 a.m. a tour was conducted of the Cyprus Court medication room with with LPN-E. Stored in the medication refrigerator was an expired vial of Aplisol. LPN-E, acknowledged the Aplisol was dated as having been opened 4/15, and was expired and available for use. A review of the manufacturer's insert for Aplisol indicated; "..Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."	21620	opened, as required, were not dated when opened, as required were removed/destroyed on 8/20/2015. Nurses received re-education on facilities policies related to checking labels on medication, removal of expired medications, and keeping medication secure in a locked medication cart, or locked medication room on 9/1/2015. Audits will becompleted weekly x 2 months, then monthly for 1 month on all medication carts / medication rooms to ensure expired medications are removed / destroyed and all medications are labeled properly for administration. Audits will be completed 3x weekly for 4 weeks, then weekly for 4 weeks, and monthly for 1 month to observe for locked medication carts and medication rooms, as well as observing for no medications left unattended / unsecured. Audit results will be reviewed by the QA committee and decisions made about further audits need. Director of Nursing / Designee will lensure proper funcioning of locks, any malfunction if not working and will report to Maintanence Department for repairs. Date of Completion : Sept. 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 37 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 5 residents (R190) on Evergreen unit and 1 of 8 residents R38 on Cypress unit. Findings include: R190 was provided assistance with her evening meal on 7/20/15, at 4:54 p.m. Nursing assistant (NA)-F was observed standing as she fed R190 her entire meal. There were chairs available for	21805	Staff have been re-educated on the policy/porcedure for assisting resident's at mealtime which inclludes the expectation that staff will be seated nest to a resident who requires staff assistance to eat their meal. 9/1/2015 Dining Room audits to monitor staff being seated while resident's eat their meal will be conducted by nursing personnel randomly including both meal times, 3x weekly for 4 weeks then 1x a week for 4	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 38 staff to use and there was space by the table to sit in a chair. R38 was provided assistance to eat her continental breakfast on 7/22/15, at 9:20 a.m. NA-G was observed standing as he fed R38 her pureed doughnut and thickened beverages. R38 was one of two residents in the dining room at the time. There were ample chairs and space to sit while helping R38 to eat. NA-H and NA-I were interviewed on 7/23/15, at 3:15 p.m. They both stated it was best to sit while assisting a resident in order to be at eye level. The unit manager, registered nurse (RN)-C was interviewed on 7/23/15, at 3:22 p.m. She explained sometimes staff would stand when they needed to move from one resident to the next, but sitting at eye level was the preferred method and best for the resident. The facility policy Assistance with Meals dated September 2013, indicated, "Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: (1) Not standing over residents while assisting them with meals." Suggested method of correction: The director of nursing (DON) or designee could provide training for all staff on the policy and procedure for assisting at mealtimes. The DON or designee could audit dining rooms at mealtime to ensure the policy is being followed and residents are provided a dignified dining experience. Time period for correction: Twenty-one (21) days.	21805	weeks then monthly. Nursing personnel will perform immediate " in - time" training upon identification of errors or opportunities for improvement. The audit will be reviewed by the QA committee and decisions made about further audits needs. The Director of Nursing / Designee is responsible to maintain compliance. Date of Complettion Sept 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 39	21810		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were within reach for use for 3 of 4 residents (R378, R38, R264), reviewed who utilized their call lights for assistance from staff. Findings include: During an interview with R378 on 7/20/15 at 6:23 p.m., R378's call light was observed wrapped around the right grab bar on the bed. R378 was seated in a recliner on the other corner of the room, on the opposite side of the bed. R378's recliner was reclined back. When asked if she was able to use her call light R378 stated "yes." At 7:07 p.m. on 7/20/15, R378 was heard from the hallway calling out "help, help" as she waved her hands. R378 was still seated in the recliner in her room and the call light remained out of reach. When the surveyor asked what R378 needed, R378 stated she wanted to go to the toilet and needed help. The surveyor summoned help and nursing assistant (NA)-C responded.	21810	The Facility policy/procedure title : "Answering Call Light" was reviewed on : 9/1/2015 Staff have been re-educated on the policy/procedure for ensuring call lights are within reach for residents use. 9/1/2015 Call light audits will be conducted randomly throughout 24 hour periods by members of nursing staff and IDT. In-time training will be conducted upon identification of errors, or oppotunities for improvement. The Audit results will be reviewed by the QA committee and decisions made about further audit needs. The Director of Nursing/designee is responsible to maintain compliance. Date of Completion: Sept. 1, 2015	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 40 NA-C stated R378's son had just been at the facility visiting and it appeared he had transferred R378 without informing staff when he'd left. During this observation, NA-C verified R378 was able to use the call light. At 7:11 p.m. on 7/20/15, registered nurse (RN)-B also stated R378 was cognitively able to use the call light. RN-B stated she would have expected staff to ensure R378's call light was within reach. R378's Resident Admission Record sheet dated 7/17/15, identified the resident's diagnoses to include: nonorganic psychosis, confusion, urinary tract infection, encephalopathy, impaired renal function and acute kidney failure. R378's Individual Resident Care Plan dated 7/17/15, indicated R378 was at risk for falls and also indicated R378 was continent but required staff assistance with toileting. On 7/23/15, at 12:43 p.m. the director of nursing (DON) stated staff were to make sure resident call lights were within reach every time staff was done assisting them. R38 was observed on 7/20/15, at 6:48 p.m. to be seated in her wheelchair located near the foot of her bed, with the television on. R38's eyes were closed but opened quickly when called by name. At the time of observation R38 wore a gown and pants. When approached R38 stated, "I am sitting here waiting for staff to put me to bed." The call light was observed to be out of R38's reach, coiled at the foot of the bed, approximately two feet behind and to the right of R38. When asked if she was able to use the call light when it was within reach R38 stated, "I can use the call light	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 41 when I want to and it is in reach; I get tired of waiting." On 7/20/15, at 6:50 p.m. licensed practical nurse (LPN)-D acknowledged R38's call light was not within reach. LPN-D stated, she does not always use call light, "sometimes she will use it; sometimes she will just call out. When I left her here, she had it (call light) in her lap. The aides must have moved it when they pulled the covers back." R38's Resident Admission Record indicated her diagnoses included: paralysis agitans-Parkinson's, congestive heart failure, and bilateral lymphedema. R38's falls Care Area Assessments (CAA) dated 5/5/15, indicated R38 was alert and able to communicate needs to staff ....Continue to incourage (sic) her to request assistance." An undated Nursing Assistant Care Sheet indicated..."Call light in reach (sic) @ [at] all times..." During observations on 7/20/15, at 3:55 p.m., R264's call light cord was observed on the floor, at the end of the bed. When interviewed, R264 stated that she used the call light but could not reach it. The admission assessment MDS dated 5/20/15 identified R264 cognitive status as 14/15. The facility's policy, Answering the Call Light revised October 2010, directed "5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident."	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 42	21810		

Based on observation, interview and document review, the facility failed to ensure call lights were within reach for use for 3 of 4 residents (R378, R38, R264), reviewed who utilized their call lights for assistance from staff.

Findings include:

During an interview with R378 on 7/20/15 at 6:23 p.m., R378's call light was observed wrapped around the right grab bar on the bed. R378 was seated in a recliner on the other corner of the room, on the opposite side of the bed. R378's recliner was reclined back. When asked if she was able to use her call light R378 stated "yes."

At 7:07 p.m. on 7/20/15, R378 was heard from the hallway calling out "help, help" as she waved her hands. R378 was still seated in the recliner in her room and the call light remained out of reach. When the surveyor asked what R378 needed, R378 stated she wanted to go to the toilet and needed help. The surveyor summoned help and nursing assistant (NA)-C responded. NA-C stated R378's son had just been at the facility visiting and it appeared he had transferred R378 without informing staff when he'd left. During this observation, NA-C verified R378 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 43 able to use the call light. At 7:11 p.m. on 7/20/15, registered nurse (RN)-B also stated R378 was cognitively able to use the call light. RN-B stated she would have expected staff to ensure R378's call light was within reach. R378's Resident Admission Record sheet dated 7/17/15, identified the resident's diagnoses to include: nonorganic psychosis, confusion, urinary tract infection, encephalopathy, impaired renal function and acute kidney failure. R378's Individual Resident Care Plan dated 7/17/15, indicated R378 was at risk for falls and also indicated R378 was continent but required staff assistance with toileting. On 7/23/15, at 12:43 p.m. the director of nursing (DON) stated staff were to make sure resident call lights were within reach every time staff was done assisting them. R38 was observed on 7/20/15, at 6:48 p.m. to be seated in her wheelchair located near the foot of her bed, with the television on. R38's eyes were closed but opened quickly when called by name. At the time of observation R38 wore a gown and pants. When approached R38 stated, "I am sitting here waiting for staff to put me to bed." The call light was observed to be out of R38's reach, coiled at the foot of the bed, approximately two feet behind and to the right of R38. When asked if she was able to use the call light when it was within reach R38 stated, "I can use the call light when I want to and it is in reach; I get tired of waiting." On 7/20/15, at 6:50 p.m. licensed practical nurse (LPN)-D acknowledged R38's call light was not within reach. LPN-D stated, she does not always	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 44 use call light, "sometimes she will use it; sometimes she will just call out. When I left her here, she had it (call light) in her lap. The aides must have moved it when they pulled the covers back." R38's Resident Admission Record indicated her diagnoses included: paralysis agitans-Parkinson's, congestive heart failure, and bilateral lymphedema. R38's falls Care Area Assessments (CAA) dated 5/5/15, indicated R38 was alert and able to communicate needs to staff ....Continue to incourage (sic) her to request assistance." An undated Nursing Assistant Care Sheet indicated..."Call light in reach (sic) @ [at] all times..." During observations on 7/20/15, at 3:55 p.m., R264's call light cord was observed on the floor, at the end of the bed. When interviewed, R264 stated that she used the call light but could not reach it. The admission assessment MDS dated 5/20/15 identified R264 cognitive status as 14/15. The facility's policy, Answering the Call Light revised October 2010, directed "5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure call lights are kept within	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 45 resident reach. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow up on resident grievances for 3 of 3 residents (R107, R5, R127). Findings include: The past few months of Resident Council meeting minutes were reviewed with approval from a representative of the council. The Resident Council meeting minutes dated 4/15/15, indicated R5 had voiced a concern about staff taking a long time to answer call lights during the day and early morning hours. According to the notes, the activity director (AD) planned to have the director of nursing (DON) speak to the group about the concern at the meeting in May of 2015. The Resident Council meeting minutes dated 5/20/15, indicated the administrator and DON had	21870	R107 Call light log is printed daily, reviewed with resident for one week. Call light concerns will be reviewed with resident, for 2 weeks or longer if not resolved. R107 Placed on an individualized toileting based on the bowel and bladder assessment. As previously care plan states client will continue to wear "peri pad" at night for comfort. 8/20/2015 R127 Residents needs will be anticipated and met based on assessment and change of condition, resident is care planned for Advanced/alzheimer's Due to contractures bi-laterally on hands.	9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 46 been present at the meeting and and spoken to the group about plans to improve staffing. The minutes indicated the DON and administrator had stressed a desire for good service, and indicated they had identified they would ensure improved staffing soon to help respond to call lights more quickly. In addition, the minutes indicated a resident again voiced a concern of waiting for assistance and indicated a family member's concern with the lack of help during meal time. The Resident Council meeting minutes dated 6/17/15, indicated R127 and R107 had voiced concerns about having to wait "too long" for help to the bathroom. The notes indicated the AD had spoken to the residents about budget issues and the shortage of nursing assistants, and indicated the AD had told the residents the administrator was "looking at the budget now." R107 was interviewed on 7/23/15, at 11:59 a.m. R107 stated she had waited for over an hour to have her call light answered and had experienced accidents "all the time" because she was not able to get on the toilet by herself. R107 stated she had to wear an incontinent pad, but would rather not. The resident said she had waited a long time "just yesterday." Nursing assistant (NA)-A was interviewed on 7/23/15, at 12:10 p.m. NA-A said R107 was mostly continent but wore a pad for dribbling accidents and wore a brief at night. The Care Area Assessment (CAA) dated 1/8/15, indicated R107 was incontinent of bladder and wore a peri pad at night "just in case." The care plan for R107, dated 4/8/15, indicated the resident was unable to toilet by herself related to mobility deficits. The goal was to use the toilet	21870	Clients call light has been changed to a soft paddle call cord 8/20/15 Resident council meeting added a follow - up concern form for the department managers. Each individual problem will be followed up for the person or reported to the group if a group concern arises. Any discrepancies will be reviewed at the weekly department managers meeting. Activity Director, Director of nursing or Designee are responsible to maintain compliance. Date of Completition: Sept 1, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 47 with staff assist and the approaches included, "peri pad at bedtime" ... "just in case. ..Own underwear during the daytime." The AD was interviewed on 7/23/15, at 1:42 p.m. She was not aware if the concern about waiting too long for help had been addressed specifically with the residents who had voiced concerns. She explained the facility did not utilize concern forms for follow up on issues, but was planning to implement such a form. In that way, concerns could be better tracked and followed up. The nurse manager registered nurse (RN)-C was interviewed on 7/23/15, at 2:05 p.m. She stated she thought the AD took care of following up on concerns. Social worker (SW)-A was interviewed at the same time. She said she was unsure about process for following up on resident issues voiced at resident council meetings. The facility policy and procedure for resident concerns, dated 8/1/08, indicated concerns were not limited to a written grievance procedure, but could include verbal concerns. The policy indicated when a resident voiced a concern to a staff member, the staff member was to complete a concern form and forward it to the social services department. Suggested method for correction: The DON and social services director could develop and operationalize a resident concern form to ensure timely follow up for resident concerns. The activity director could ensure all voiced concerns from resident council are forwarded to the correct staff member for follow up.	21870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAK	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 48 Time period for correction: Twenty-one (21) days.	21870		