DEPARTMENT OF HEALTH	AND HUMA	N SERVICES		CENTERS FOR MEDICARE & MEDICAID SERVICES				
	MEDIC	ARE/MEDICAII	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: HM6Y		
	PART I -	TO BE COMPL	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00923		
MEDICARE/MEDICAID PROVIDER (L1) 245300 2.STATE VENDOR OR MEDICAID NO (L2) 253342100		3. NAME AND AD (L3) CERENITY (L4) 1891 FLORH (L5) WHITE BEA	CARE CENT ENCE STREE	ER - WHI T	TE BEAR LAKE (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		
5. EFFECTIVE DATE CHANGE OF OV (L9) 01/01/2001		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 09/11/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 08/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	ΔS·				
From (a):		X A. In Complian		715.	And/Or Approved Waivers Of	The Following Requirements:		
To (b):		•	equirements		2. Technical Personnel			
		-	e Based On:		3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds	138 (L18)	1. Ad	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	IF)8. Patient Room Size 9. Beds/Room		
13.Total Certified Beds	138 (L17)		pliance with Prog ents and/or Appli		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS			
18 SNF 18/19 SNF 138	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Gayle Lantto, Unit Supervis	or	0	9/21//2015	_(L19) k	Kamala Fiske-Downing. Enforcement Specialist 09/24/2015 (L20)			
PAR	Г II - TO BE	COMPLETED E	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY		
 DETERMINATION OF ELIGIBILIT <u>X</u> 1. Facility is Eligible to Par <u>2</u>. Facility is not Eligible 			PLIANCE WITH ITS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 12/01/1985	BEGINNING	G DATE	ENDING DA	ГЕ	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>		
	A. Suspensio	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	09/09/2015		(L33)	DETERMINATION APPI	ROVAL		



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,

Kumalu Fiske Downing

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



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 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,

Kumalu Fiske Downing

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

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245300	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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
	F0241 483.15(a)		Correction Completed 09/01/2015		F0244 483.15(c)(6)		Correction Completed 09/01/2015			F0246 483.15(e)(1)		Correction Completed 09/01/2015
ID Prefix Reg. # LSC	F0278 483.20(g) - (i)		Correction Completed 09/01/2015	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 09/01/2015		ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 09/01/2015
ID Prefix Reg. # LSC	483.25(h)		Correction Completed 09/01/2015	ID Prefix Reg. # LSC	F0333 483.25(m)(2)		Correction Completed 09/01/2015		ID Prefix Reg. # LSC	F0371 483.35(i)		Correction Completed 08/20/2015
	F0411 483.55(a)		Correction Completed 09/01/2015	ID Prefix Reg. # LSC	483.60(b), (d), (e)		Correction Completed 09/01/2015			F0441 483.65		Correction Completed 09/01/2015
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC					D //			
Reviewed I		Reviewed	Ву	Date:	Signature	of Sur		5507			Date:	
State Agen Reviewed I CMS RO		GL/kfd Reviewed	Ву	09/21/20 Date:	15 Signature	of Sur		,507			09/1 Date:	1/2015
Followup	to Survey Com 7/23/2	-	1:		Check for any Uncorrected					Summary of the Facility?	YES	NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245300	(Y2) Multiple Cons A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 9/18/2015		
Name of Facility		Street Address, City, State, Zip Code				
CERENITY CARE CENTER - WHITE E	EAR 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	()	(4) Item		(Y5)	Date
		Correction			Correct	on				Correction
ID Prefix		Completed 08/20/2015	ID Prefix		Comple 08/20/2	ted 015	ID Prefix			Completed 08/20/2015
-	NFPA 101		•	NFPA 101			•	NFPA 101		
LSC	K0025		LSC	K0029			LSC	K0062		
		Correction			Correct	on				Correction
ID Prefix		Completed 08/20/2015	ID Prefix		Comple	ted	ID Prefix			Completed
Reg. #	NFPA 101		Reg. #							
	K0076						LSC			
		Correction			Correct	on				Correction
D Drofiv		Completed	ID Drofiv		Comple	ted	ID Drofiv			Completed
ID Prefix										
Reg. # LSC			Reg. #				Reg. # LSC			
		Correction			Correct	on				Correction
ID Prefix		Completed	ID Prefix		Comple	ted	ID Prefix			Completed
Reg. #			Reg. #				Reg. #			
			LSC							
		Correction			Correct	on				Correction
ID Prefix		Completed	ID Prefix		Comple	ted	ID Prefix			Completed
Reg. #			Reg. #				D //			
			LSC				LSC			
Reviewed I	By F	Reviewed By	Date:	Signature	of Surveyor:				Date:	
State Agen	cy G	S/kfd	09/21/201	5		124	124	09		09/18/2015
Reviewed I CMS RO	By F	Reviewed By	Date:	Signature	e of Surveyor:				Date:	
Followup	to Survey Com 7/23/2				y Uncorrected				YES	NO
		-	1							

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245300	(Y2) Multiple Cons A. Building B. Wing		3 ADDITION	(Y3) Date of Revisit 9/18/2015		
Name of Facility		Street Address, City, State, Zip Code				
CERENITY CARE CENTER - WHITE B	EAR 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	(Y:	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction			Correction			Correction
ID Prefix		Completed 08/20/2015	ID Prefix		Completed 08/20/2015	ID Prefix		Completed 08/20/2015
-	NFPA 101			NFPA 101	_		NFPA 101	
LSC	K0011	_	LSC	K0025	-	LSC	K0029	
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #			D "		
		_			-	LSC		
		Correction			Correction			Correction
ID Profix		Completed			Completed	ID Profix		Completed
					-			
Reg. # LSC		_	Reg. # LSC		-	LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #					_			
		_	LSC		-	LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #						D //		
LSC		_	LSC		-	LSC		
Reviewed E	By Reviewe	d By	Date:	Signature of Su			Date:	
State Agen			09/21/201	5	12424		09/18/2015	
Reviewed E CMS RO	3y Reviewe	d By	Date:	Signature of Su	rveyor:		Date:	
Followup t	o Survey Completed o 7/23/2015	on:		Check for any Unco Uncorrected Defi				NO

DEPARTMENT OF HEALTI	I AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES			
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION	AND TRANSMITTAL	ID: HM6Y			
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00923			
1. MEDICARE/MEDICAID PROVIDE (L1) 245300 2.STATE VENDOR OR MEDICAID N (L2) 253342100		3. NAME AND AE (L3) CERENITY (L4) 1891 FLORI (L5) WHITE BE A	CARE CENT ENCE STREE	ER - WHI T	TE BEAR LAKE (L6) 55110	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint			
5. EFFECTIVE DATE CHANGE OF ((L9) 01/01/2001	OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint 			
6. DATE OF SURVEY 07/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	3/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 08/31			
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	138 (L18) 138 (L17)	Complianc	nce With equirements e Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director			
13. Total Certified Deus	130 (217)	Requireme	ents and/or Appli	ed Waivers:	* Code: B *	(L12)			
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS				
18 SNF 18/19 SNF 138	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:			
Lou Ann e Page HFE NE I	I	0	8/25/2015	(L19)	Kamala Fiske-Downing, Enforcement Specialist 09/04/2015				
PAL	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	L OFFICE OR SINGLE S	TATE AGENCY			
 DETERMINATION OF ELIGIBIL 1. Facility is Eligible to P 2. Facility is not Eligible 			IPLIANCE WITH ITS ACT:	H CIVIL	 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 				
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)			
OF PARTICIPATION 12/01/1985	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	· · · · · · · · · · · · · · · · · · ·			
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L27) B. Rescind Suspension Date:			(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active			
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE					
	(L32)			(L33)	DETERMINATION APPI	ROVAL			



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:

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

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

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

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

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

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

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,

moton

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		245300	B. WING	o	7/23/2015
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
CERENII	Y CARE CENTER - V	VHITE BEAR LAKE		891 FLORENCE STREET NHITE BEAR LAKE, MN 55110	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 000	INITIAL COMMEN	rs	F 000		
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 241 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with YAND RESPECT OF	F 241		9/1/15
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observat review, the facility f dining experience f Evergreen unit and Cypress unit.	NT is not met as evidenced tion, interview and document ailed to provide a dignified or 1 of 5 residents (R190) on 1 of 8 residents R38 on		Staff have been re-educated on the policy/porcedure for assisting resident's mealtime which inclludes the expectation that staff will be seated nest to a residen who requires staff assistance to eat their meal. 9/1/2015	n t
	meal on 7/20/15, at (NA)-F was observe her entire meal. Th	assistance with her evening 4:54 p.m. Nursing assistant ed standing as she fed R190 ere were chairs available for re was space by the table to		Dining Room audits to monitor staff bein seated while resident's eat their meal wil 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	Ī

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

PRINTED: 08/21/2015

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUC	CTION (>	K3) DATE	0938-039
AND PLAN (F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	IG		COM	PLETED
		245300	B. WING _			07/2	23/2015
NAME OF	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE		
CERENI	Y CARE CENTER - W	HITE BEAR LAKE		1891 FLOREN	ICE STREET R LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241 F 244 SS=D	continental breakfa NA-G was observed pureed doughnut at was one of two resi time. There were at while helping R38 to NA-H and NA-I wer 3:15 p.m. They both assisting a resident The unit manager, f interviewed on 7/23 explained sometime needed to move fro but sitting at eye lev and best for the resi The facility policy At September 2013, in cannot feed themse to safety, comfort a Not standing over re with meals." 483.15(c)(6) LISTE GRIEVANCE/RECO When a resident or must listen to the vi grievances and reco and families concer operational decision life in the facility.	assistance to eat her st on 7/22/15, at 9:20 a.m. d standing as he fed R38 her nd thickened beverages. R38 dents in the dining room at the mple chairs and space to sit o eat. e interviewed on 7/23/15, at n stated it was best to sit while in order to be at eye level. registered nurse (RN)-C was /15, at 3:22 p.m. She es staff would stand when they m one resident to the next, vel was the preferred method ident. ssistance with Meals dated ndicated, "Residents who elves will be fed with attention nd dignity, for example: (1) esidents while assisting them N/ACT ON GROUP	F 24	will perfo upon ide opportun The audi committe further au The Dire responsil Date of C	rm immediate " in - time" tra ntification of errors or ities for improvement. t will be reviewed by the QA ee and decisions made abou- udits needs. ctor of Nursing / Designee is ble to maintain compliance. Completion Sept 1, 2015	ıt S	9/1/15

Facility ID: 00923

If continuation sheet Page 2 of 40

	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		0938-039 E SURVEY	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G	· · ·	PLETED	
		245300	B. WING		07/	23/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
CERENI	Y CARE CENTER - V	VHITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE	
F 244	Continued From pa	ae 2	F 24	4			
	by:	-0 -					
		v and document review, the		R107 Call light log is printed dail	у,		
		w up on resident grievances		reviewed with resident for one we			
	for 3 of 3 residents	(R107, R5, R127).		light concerns will be reviewed will			
				resident, for 2 weeks or longer if	not		
	Findings include:			resolved.			
	The past few month	ns of Resident Council		R107 Placed on an individualized	l toiletina		
		ere reviewed with approval		based on the bowel and bladder	rionoting		
		ve of the council. The		assessment.			
		neeting minutes dated 4/15/15,					
		piced a concern about staff		As previously care plan states cli			
		o answer call lights during the		continue to wear "peri pad" at nig	ht for		
		ing hours. According to the lirector (AD) planned to have		comfort. 8/20/2015			
		ing (DON) speak to the group		R127 Residents needs will be an	ticipated		
		at the meeting in May of 2015.		and met based on assessment a			
		0, 2		change of condition, resident is c			
		ncil meeting minutes dated		planned for Advanced/alzheimer'			
		he administrator and DON had		contractures bi-laterally on hands			
		e meeting and and spoken to		Cliente cell light has been abang	nd to o		
		Ins to improve staffing. The he DON and administrator had		Clients call light has been change soft paddle call cord 8/20/15	eu lo a		
		or good service, and indicated		son paddle call cord 0/20/13			
		they would ensure improved		Resident council meeting added	a follow -		
	staffing soon to hel	p respond to call lights more		up concern form for the departme	ent		
		, the minutes indicated a		managers. Each individual probl			
		ed a concern of waiting for		be followed up for the person or r			
		cated a family member's ck of help during meal time.		to the group if a group concern a	nses.		
		ck of help during meat time.		Any discrepancies will be reviewe	d at the		
	The Resident Cour	cil meeting minutes dated		weekly department managers me			
		R127 and R107 had voiced			Ũ		
		ving to wait "too long" for help		Activity Director, Director of nursi			
		ne notes indicated the AD had		Designee are responsible to main	ntain		
		ents about budget issues and		compliance.			
		sing assistants, and indicated residents the administrator		Date of Completition: Sept 1, 201	5		
	was "looking at the			Date of Completition. Sept 1, 201	5		

		AND HUMAN SERVICES				FORM	: 08/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245300	B. WING			07/	23/2015
NAME OF I	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CERENI	TY CARE CENTER - V	VHITE BEAR LAKE			891 FLORENCE STREET VHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 244	Continued From pa	ige 3	F 2	44			
	R107 was interview R107 stated she ha have her call light a accidents "all the tin to get on the toilet b had to wear an inco not. The resident sa "just yesterday." Nursing assistant (I 7/23/15, at 12:10 p. mostly continent bu accidents and wore The Care Area Ass indicated R107 was wore a peri pad at r plan for R107, date resident was unable mobility deficits. Th with staff assist and "peri pad at bedtime underwear during th The AD was intervie She was not aware too long for help ha with the residents w explained the facilit for follow up on issu implement such a f could be better trace The nurse manage interviewed on 7/23 she thought the AD concerns. Social we	ved on 7/23/15, at 11:59 a.m. ad waited for over an hour to inswered and had experienced me" because she was not able by herself. R107 stated she portinent pad, but would rather aid she had waited a long time NA)-A was interviewed on .m. NA-A said R107 was it wore a pad for dribbling a brief at night. essment (CAA) dated 1/8/15, s incontinent of bladder and hight "just in case." The care d 4/8/15, indicated the e to toilet by herself related to e goal was to use the toilet d the approaches included, e" "just in caseOwn					

Facility ID: 00923

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		& MEDICAID SERVICES	1	OM	FORM APPROVE B NO. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	X3) DATE SURVEY COMPLETED	
		245300	B. WING		07/23/2015	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER - V	VHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 244 F 246 SS=D	process for followir voiced at resident of The facility policy a concerns, dated 8/ not limited to a writ could include verba indicated when a re staff member, the s a concern form and services departmen 483.15(e)(1) REAS OF NEEDS/PREFE A resident has the services in the facil accommodations o preferences, except	ng up on resident issues council meetings. nd procedure for resident 1/08, indicated concerns were ten grievance procedure, but al concerns. The policy esident voiced a concern to a staff member was to complete d forward it to the social nt. SONABLE ACCOMMODATION ERENCES	F 24		9/1/15	
	by: Based on observa review, the facility f within reach for use R38, R264), review for assistance from Findings include: During an interview p.m., R378's call lig around the right gra seated in a recliner	NT is not met as evidenced tion, interview and document ailed to ensure call lights were e for 3 of 4 residents (R378, red who utilized their call lights a staff. with R378 on 7/20/15 at 6:23 ght was observed wrapped ab bar on the bed. R378 was on the other corner of the site side of the bed. R378's		The Facility policy/procedure title : "Answering Call Light" was reviewed 9/1/2015 Staff have been re-educated on the policy/procedure for ensuring call ligh are within reach for residents use. 9/1/2015 Call light audits will be conducted randomly throughout 24 hour periods members of nursing staff and IDT. In-time training will be conducted upon	nts s by	

Facility ID: 00923

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PRINTED: 08/21/2015 FORM APPROVED

	OF DEFICIENCIES	KANNER STATE AND A STATE		PLE CONSTRUCTION G	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245300	B. WING		07/	23/2015	
	PROVIDER OR SUPPLIER	VHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP 1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110	CODE	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION N SHOULD BE	(X5) COMPLETIC DATE	
F 246	was able to use he At 7:07 p.m. on 7/2 the hallway calling her hands. R378 w her room and the coreach. When the su needed, R378 state toilet and needed h help and nursing as NA-C stated R378's facility visiting and in R378 without inform During this observa- able to use the call At 7:11 p.m. on 7/2 also stated R378 w call light. RN-B state staff to ensure R37 R378's Resident Ac 7/17/15, identified to include: nonorganic tract infection, ence function and acute Individual Resident indicated R378 was assistance with toil On 7/23/15, at 12:4 (DON) stated staff	ad back. When asked if she r call light R378 stated "yes." 20/15, R378 was heard from out "help, help" as she waved as still seated in the recliner in call light remained out of urveyor asked what R378 ed she wanted to go to the help. The surveyor summoned ssistant (NA)-C responded. s son had just been at the it appeared he had transferred ming staff when he'd left. ation, NA-C verified R378 was light. 0/15, registered nurse (RN)-B vas cognitively able to use the ted she would have expected '8's call light was within reach. dmission Record sheet dated the resident's diagnoses to c psychosis, confusion, urinary ephalopathy, impaired renal kidney failure. R378's Care Plan dated 7/17/15, s at risk for falls and also s continent but required staff eting. 43 p.m. the director of nursing were to make sure resident in reach every time staff was	F 24	 6 identification of errors, or o improvement. The Audit results will be read a committee and decision further audit needs. The Director of Nursing/de responsible to maintain compate of Completion: Sept. 	viewed by the ns made about signee is mpliance.		

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		AND HUMAN SERVICES				FORM	08/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245300	B. WING	à	·····	07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER	·	-		TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	TY CARE CENTER - W	VHITE BEAR LAKE			891 FLORENCE STREET VHITE BEAR LAKE, MN 55110		
	SUMMARY STA	TEMENT OF DEFICIENCIES	П	v	PROVIDER'S PLAN OF CORRECTIO		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 246	Continued From pa	ge 6	F	246			
		chair located near the foot of					
		levision on. R38's eyes were					
		quickly when called by name. rvation R38 wore a gown and					
	pants. When appro	ached R38 stated, "I am					
		for staff to put me to bed." The ved to be out of R38's reach,					
	coiled at the foot of	the bed, approximately two					
		he right of R38. When asked if the call light when it was					
	within reach R38 st	ated, "I can use the call light					
	when I want to and waiting."	it is in reach; I get tired of					
	(LPN)-D acknowled within reach. LPN-E use call light, "some sometimes she will here, she had it (ca	p.m. licensed practical nurse dged R38's call light was not 0 stated, she does not always etimes she will use it; just call out. When I left her Il light) in her lap. The aides t when they pulled the covers					
	diagnoses included	s, congestive heart failure, and					
	5/5/15, indicated R3 communicate need	ea Assessments (CAA) dated 38 was alert and able to s to staffContinue to to request assistance."					
		g Assistant Care Sheet nt in reach (sic) @ [at] all					
	During observations	s on 7/20/15, at 3:55 p.m.,					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		IDENTIFICATION NOMBER.	A. BUILDIN	NG	001	
		245300	B. WING _		07/	23/2015
	PROVIDER OR SUPPLIER	VHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 246 F 278	R264's call light con at the end of the be stated that she use reach it. The admission asso identified R264 cog The facility's policy, revised October 20 resident is in bed of the call light is withi	A was observed on the floor, ad. When interviewed, R264 d the call light but could not essment MDS dated 5/20/15 nitive status as 14/15. Answering the Call Light 10, directed "5. When the r confined to a chair be sure n easy reach of the resident."	F 24			9/1/15
SS=D	ACCURACY/COOF The assessment m resident's status.	RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate vith the appropriate				0,1,10
	assessment is com Each individual who assessment must s that portion of the a Under Medicare an willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material resident assessment	o completes a portion of the sign and certify the accuracy of				

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	TH AND HUMAN SERVICES			PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	B. WING		07/23/2015
NAME OF PROVIDER OR SUPPI			DE	
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
material and fail This REQUIRE by: Based on inter facility failed to (MDS) assess residents (R319 catheter. Findings includ R319's hospital the physican ar had been disch indwelling Foley An initial MDS of dated 6/25/15, Foley catheter, corresponding of catheter. On 7/21/15, at (RN)-D was inter for the use of a R319. RN-D refined On 7/22/15, at MDS assessment	ement does not constitute a se statement. MENT is not met as evidenced view and document review, the ensure the Minimum Data Set nent was accurate for 1 of 3)) who utilized an indwelling Foley	F 2		n 7/29 noved. Catheter IDS uracy Foley racy of the eted with completing to the MDS ext 4 weeks, review nd verifing a he use of the ignee and ponsible to

If continuation sheet Page 9 of 40

ATEMENT	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		245300	B. WING		07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	Y CARE CENTER - \	WHITE BEAR LAKE		891 FLORENCE STREET NHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 278	Continued From pa	-	F 278			
	the Resident Asses	S, RN-G said the policy follows ssment Instrument (RAI) npleting all sections of the				
F 282 SS=D	Resident Assessm Version 3.0 last rev of the items in the information on the appliances, the use toileting programs, bowel training prog "Each resident who developing incontir assessed, and pro treatment (medicat and/or devices) an maintain as norma possible." In addition Steps for Assessm "1. Examine the re any urinary or bown 2. Review the med and bowel records or past use of urina	ical record, including bladder , for documentation of current ary or bowel appliances." RVICES BY QUALIFIED	F 282			9/1/15
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of				
	by:	NT is not met as evidenced tion, interview and document		R92 was reassessed to determir		

Facility ID: 00923

If continuation sheet Page 10 of 40

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · /	E SURVEY PLETED
	of Connection	IDENTIFICATION NOMBER.	A. BUILDIN	à		COM	
		245300	B. WING				23/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRES: 1891 FLORENCE	S, CITY, STATE, ZIP COI	DE	
CERENI	Y CARE CENTER - V	VHITE BEAR LAKE					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORR CORRECTIVE ACTION S EFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 282	Continued From pa	ge 10	F 28	2			
	review, the facility f	ailed to follow the plan of care (R92) reviewed who was at			ed for supervision/a on 8/20/2015	assistance	
	Findings include:				plan was reviewed needs and interven		
	seated in the dining drinking independe be in the DR at that a bite of pureed con the registered dietic towards the Cedar medication aide (TI past towards the C R92 took another b of nursing (DON) a were both observed took a sip using a s entered the DR an asked R92 whether	0 p.m. R92 was observed g room (DR) eating and ntly, no staff were observed to t time. At 12:11 p.m. R92 took nsistency food. At 12:15 p.m. cian (RD) went past the DR unit. At 12:16 p.m. the trained MA)-A was observed to walk ypress Unit nursing station as ite. At 12:17 p.m. the director nd human resource director d to pass the DR while R92 straw. At that time TMA-A d sat next to R92. TMA-A r she wanted to eat some eded help to which R92		on the experience on the experience of the exper	om observation auc for both meals 3x n weekly for 1 mor month to ensure r been assessed to r n are not left unatte	aff follow the dits will be weekly for 1 th, and esidents equire ended in the insure pervision.	
	replied, "No." TMA- and was observed R92 was observed	A continued to sit next to R92 assisting her. At 12:23 p.m. to be done eating but TMA-A he table and assisted R92 to		or staff guid The Directo responsible	dance are required or of Nursing/Desig e for maintaining co mpletion: Sept 1, 2	l. gnee is ompliance	
	dated 2/26/15, indic potential for alterati loss, self-feeding di chewing/swallowing Parkinson's disease						
	a chewing problem	ted 3/7/11, indicated R92 had related to Parkinson's. The staff to observe R92 closely for					

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		245300	B. WING		07/	23/2015
				TREET ADDRESS, CITY, STATE, ZIP CODE 891 FLORENCE STREET	•	
EREINI	TY CARE CENTER - V		v	VHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 309	aspiration, and to p physical help as ne indicated R92 dem alteration in nutrition self-feeding difficul difficulty related to slowly eating and of encouragement to directed staff to pro- reminders and phy the resident was ea R92's undated nut assignment sheet assist with eating . On 7/22/15, at 12:2 (RN)-C stated R92 with meals. RN-C supposed to be in was eating. RN-C problems with swa disease. At the tim also acknowledged left unsupervised w On 7/23/15, at 12:2 acknowledged R92 been followed and be in the dining roo staff person was so room when [R92] a 483.25 PROVIDE HIGHEST WELL E	signs of choking and/or provide setup help, cueing, and eeded. In addition the care plan nonstrated potential for on due to weight loss, Ity and chewing/swallowing Parkinson's disease with very drinking behaviors, and refusing eat and drink. The care plan ovide setup help, frequent vsical assist for meals because asily distracted during meals. rsing assistant (NA) directed staff to provide "Total " 28 p.m. registered nurse was supposed to be assisted acknowledged staff were the DR with R92 when R92 further stated R92 had llowing due to Parkinson's e of the conversation NA-A d R92 was not supposed to be when eating. 44 p.m. the DON 2's plan of care should have stated, "staff are supposed to om until all residents are out. A upposed to be in the dining ate." CARE/SERVICES FOR	F 282			9/1/15

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED
		245300	B. WING		07/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	Y CARE CENTER - W	HITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 309	mental, and psycho	ge 12 nest practicable physical, psocial well-being, in e comprehensive assessment	F 30	9		
	by: Based on observat review, the facility fa non-pressure relate residents (R239) wi Findings include: R239 was observed a large bruise on th small bruises on the interviewed and wa gotten the bruises. bruises, R239 was area on the left thur hurt. On 7/21/15, at 10:1 his room seated on observed to have th the left thumb. On 7/22/15, at 7:41 R239's left thumb a addition, two small observed to be dark	NT is not met as evidenced tion, interview and document ailed to adequately monitor ed skin conditions for 1 of 2 th observed bruising. d on 7/20/15, at 4:11 p.m. with e left thumb area and two e right arm area. R239 was s not able to indicate how he'd When asked about the observed to rub the bruised mb which R239 stated did not 0 a.m. R239 was observed in the recliner. R239 was still he large dark purple bruise on a.m. the large dark bruise on trea was still present. In bruises on his right arm were c purple. 4 p.m. the left thumb bruise		R239 Had an event report comp the identified bruises. R239's family and physician wer aupdated and notified about the observed on the right and left the R239's bruises on the thumb and arm have healed. The care plan was updated to re current resident's needs and interventions. Residents who have been identifi have bruising have had the bruis assessed and " daily observation bruise till resolved" added to the The facility policy /procedure title Audit" was reviewed/revised on a Staff has been reeducated on th ezpectations for reporting bruisir skin impairments upon observati routine monitoring of the bruise to resolved.	e bruises umb. d right flect the flect the ited to e of the eTar. s "Body 3/20/15. e ig and on and	
	was still observed to Review of R239's P	o be present. Progress Notes dated 7/1/15,		Residents are observed for area bruising with AM and HS cares. skin observations are completed	Weekly	

Facility ID: 00923

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		245300	B. WING		07	
	PROVIDER OR SUPPLIER	245500		STREET ADDRESS, CITY, STATE, ZIP CODE	07/23/2015	
	TY CARE CENTER - V	WHITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110	=	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 309	assessment of the had brought this co staff, a nursing Pro- indicated R239 had and two bruises on indicated the meas the bruises were as - Bruise on left thun 2.0 cm dark purple - Bruises on right fo bruise closer proxin and distal to elbow R239's care plan d was at risk for skin decreased mobility directed staff to co inspection with dail indicated staff were the bony prominen skin breakdown (so areas). During interview wi unit manager of the on 7/23/15 at 10:55 impulsive and had TCU which had ca RN-A stated R239 (blood thinner med review of the progr assessments, that monitoring of R23 staff were expected noted, RN-A stated to the nurse and th	icked documentation of any bruises. After the surveyor oncern to the attention of the ogress Note dated 7/23/15, d one bruise on the left thumb a the right arm. The note surements and description of s follows: mb was 4.2 centimeter (cm) by in color. orearm same dark purple with mity to elbow 1.8 cm by 1.6 cm 1.0 cm by 1.5 cm. lated 7/3/15, indicated R239 breakdown related to c. Care plan interventions nduct a systematic skin by cares and weekly bath and e to pay particular attention to ces and report any signs of ore, tender, red, or broken ith the registered nurse (RN)-A e Transitional Care Unit (TCU) 5 a.m., RN-A stated R239 was fallen during his stay in the used bruising. In addition, had a history of Coumadin lication) use. RN-A verified with ess notes and weekly skin risk there had not been routine 9's bruises. When asked what d to do when bruising was d staff were supposed to report at resident bruising should ed on the body audit forms	F 309	 9 nurse and findings are documented progress notes. Audits of the weekly skin observation of the resident will be completed 3 x weekly for 4 weeks weekly x 4 weeks and then month monthto monitor for compliance for reporting and monitoring. The Director of Nursing/Designee responsible for maintaining completed of completion: Sept. 1, 2015 	ion I , then Iy x1 or is	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245300	B. WING			07/:	23/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 391 FLORENCE STREET		
CERENIT	Y CARE CENTER - W	HITE BEAR LAKE			HITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 14	F 3	09			
	At 11:05 a.m. on 7/2 reported resident bi bruises. RN-D also morning, and she th the post fall assess the bruises and rep At 12:45 p.m. on 7/2 (DON) stated she e skin changes to the that when the week the nurse was supp Although a body au 7/20/15, no bruising The facility's Body A indicated the purpo all residents for idea	23/15, RN-D stated when staff ruising, she would assess the stated R239 had fallen that nought the nurse conducting ment should have identified					
F 323 SS=D	as needed to Interd Physician/NP (nursi regarding any chan 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	isciplinary Team, e practitioner) and Family ges in skin integrity" FACCIDENT	F 3	23			9/1/15
	by:	NT is not met as evidenced ion, interview, and document			R92 was re-assessed to determine)	

Facility ID: 00923

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PRINTED: 08/21/2015

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245300	B. WING			23/2015
	PROVIDER OR SUPPLIER	VHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 323	review, the facility fi supervision with a r who was at risk for accidents during a f Findings include: R92's diagnoses im cerebrovascular dis speech language th dementia obtained Record sheet dated On 7/22/15, at 12:1 seated in the dining drinking herself and time nor around or -At 12:11 p.m. R92 consistency food ou -At 12:15 p.m. the r past the DR toward -At 12:16 p.m. the t (TMA)-A was obser Cypress Unit nursin R92 took a bite. -At 12:17 p.m. the c human resource din past the DR and at cart. At this same ti straw. -At 12:17 p.m. TMA next to R92 and as some more and if s stated "No." TMA-A and was observed a -At 12:23 p.m. over she was done eatin	ailed to provide the necessary meal for 1 of 3 residents (R92) aspiration reviewed for random observation. cluded dysphagia, pneumonia, sease, cough symptom, nerapy, paralysis agitans and from Resident Admission d 7/23/15. 0 p.m. R92 was observed g room (DR) eating and d no staff was in the DR at the close by. took a bite of pureed ut of the plate. registered dietician (RD) went ls Cedar unit. trained medication aide rved go by went towards the ng station at the same time director of nursing (DON) and rector were both observed go the time DON was pushing a ime R92 took a sip using a	F 32	 3 current need for supervision/ass with meals. The care plan has been reviewed needs and interventions are current The Facility policy / procedure in "Assistance with meals was reviewed. Staff have also been re-educate expectations for residents who assessed to require supervision assistance with meals are not le unattended. Audit results will be reviewed by committee and decisions made further audit needs. The Director of Nursing / Desig reponsible for maintaining comp Date of Completion: Sept. 1, 20 	ed to verify rrent. htled iewed / ed on the have been of eft the QA about hee is pliance.	

STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039		
		IDENTIFICATION NOMBER.	A. BUILDIN	IG	COMPLETED 07/23/2015			
		245300	B. WING _					
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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE		
F 323	On 7/22/15, at 12:2 (RN)-C stated R92 with meals. RN-C a supposed to be in t RN-C further stated swallowing and had time of the convers also acknowledged left unsupervised w On 7/23/15, at 12:4 with aspiration risk dining room until al person was suppose dietary staff." R92's nutritional Ca dated 2/26/15, india potential for alteration loss, self feeding di chewing/swallowing Parkinson's diseas assistance and sup R92's care plan date a chewing problem care plan directed so difficulty chewing, so aspiration and to pu physical help as ne dated 3/10/11, india potential for alteration loss, self feeding di chewing/swallowing Parkinson's diseas aspiration and to pu physical help as ne dated 3/10/11, india potential for alteration loss, self feeding di chewing/swallowing Parkinson's diseas drink behaviors and eat and drink. Care	28 p.m. registered nurse was supposed to be assisted acknowledged staff was the DR with R92 at the time. d R92 had problems with d Parkinson's disease. At the sation nursing assistant (NA)-A R92 was not supposed to be when eating. 44 p.m. DON stated "anybody staff are supposed to be in the l residents are out. A staff sed to be in the dining room or are Area Assessment (CAA) cated R92 demonstrated ion in nutrition due to weight ifficulty and g difficulty related to e. CAA indicated R92 received bervision at meals. ted 3/7/11, indicated R92 had related to Parkinsons. The staff to observe R92 closely for signs of choking and/or rovide setup help, cueing, and eeded. In addition care plan cated R92 demonstrated ion in nutrition due to weight ifficulty and g difficulty related to e with very slowly eating and d refusing encouragement to e plan directed staff to provide at reminders and physical	F 32					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	COM	PLETED
		245300	B. WING		07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	Y CARE CENTER - W	HITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 323	Continued From pa distracted during m	-	F 323	3		
F 333 SS=D	Assistance with Me 2013, directed: "1. Dining Room Re a. All residents the dining room. b. Facility Staff will help residents we eating. c. Residents we be fed with attention dignity," 483.25(m)(2) RESI SIGNIFICANT MED The facility must en any significant med	will be encouraged to eat in will serve resident trays and who require assistance with no cannot feed themselves will n to safety, comfort and DENTS FREE OF D ERRORS usure that residents are free of ication errors.	F 333	3		9/1/15
	by: Based on observat review, the facility f free of significant in 1 of 4 residents (RS Findings include: R55's admission M 6/22/15, indicated F cognitively impaired diabetes mellitus.	NT is not met as evidenced ion, interviews and document ailed to ensure residents were isulin administration errors for 55). inimum Data Set (MDS) dated R55 was moderately d and had a diagnosis of der dated 6/19/15, directed		 1 to 1 education provided to Rn-E regarding use of Flex Pen on 7/23 A medication error report was comper facility policy on 7/23/15 R55 insulin orders were reviewed physician on 7/23/15 Residents with insulin orders, who insulin administered with a flex pen had their orders and blood glucou monitoring results reviewed with the second s	9/15 npleted with the o have n, have se	

Event ID:HM6Y11

Facility ID: 00923

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DEPARTMENT OF HEALTH				FORM	08/21/2015 APPROVED
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY PLETED
	245300	B. WING _		07/2	23/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CERENITY CARE CENTER - W	HITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110)	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
 (medication used to unit/ml (3 ml) 22 un hour of sleep (HS). insulin order dated Humalog KwikPen blood sugar 200 to blood sugar 250 to During observation registered nurse (R R55's Lantus Solos top of the pen with a needle and dial up a the SoloStar insulin observed to prepare pen by wiping the to wipe, attach a need scale 10 units subc sugar of 255. RN-B 7:15 a.m. RN-B gav left arm. When inter a.m. RN-B stated "V R55 did not receive ordered by the phys administered 22 un 24 units and neither accurate dose was When interviewed of medical doctor (MD dosage due to rece the 400 range wher range." MD-F stated pens would be a nu cause a significant 	Lantus Solostar insulin o control blood sugar) pen 100 its before breakfast and at R55 also had a sliding scale 7/17/15. The order read: 100 unit/ml per sliding for 249 give seven units, for 299 give 10 units. on 7/23/15, at 7:12 a.m. N)-B was observed to prepare tar insulin pen by wiping the an alcohol wipe, attach a 22 units. RN-B did not prime pen. At 7:14 a.m. RN-B was e R55's Humalog KwikPen op of the pen with an alcohol lle and dial up Humalog sliding utaneous (SQ) for a blood did not prime the KwikPen. At ve both injections to R55 in his rviewed on 7/23/15, at 7:15 We do not prime Flex pens."	F 3		on medication w to accurately isulin using a 5, 7/23/15, cation/return se a flex pen or newly hired aily x 2 weeks, s, then weekly or q month to h insulin pen is used. onel training all Nursing staff cen will be obtained itation. signee is g compliance.	

Facility ID: 00923

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PRINTED: 08/21/2015 FORM APPROVED

CENTER	15 FOR MEDICARE	& MEDICAID SERVICES	1				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245300	B. WING		·····	07/23/2015	
NAME OF I	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	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
	prepare an insulin p wipe the tip of the in wipe, attach a need push the top of the and then dial the do receive. She stated insulin pen you will insulin. She stated insulin pens. The package insert Dispensing Solution directed the provide	n June of 2015. She stated to ben for injection a nurse would nsulin pen off with an alcohol lle, dial up two units of insulin, pen to prime the insulin pen ose that the resident is to that if you do not prime an not give the correct dose of staff was trained on using tor Lantus SoloStar insulin by ns, Inc. revised on 9/20/11, er/consumer to conduct a e the accuracy of dispensing		333			
	the insulin to preven The instructions we Perform a Safety te Always perform the injection. Performin you get an accurate ensuring that p removing air bu A. Select a dose of selector. B. Take off the oute remove the used ne the inner needle ca C. Hold the pen wit D. Tap the insulin re	nt under-dosing or overdosing. ere as followed: "Step 3. est Safety test before each og the safety test ensures that e dose by: en and needle work properly ubbles 2 units by turning the dosage er needle cap and keep it to eedle after injection. Take off p and discard it. h the needle pointing upwards. eservoir so that any air					
	if insulin comes out You may have to pe times before insulin If no insulin cor	on button all the way in. Check of the needle tip. erform the safety test several					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245300	B. WING			07/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER - W	/HITE BEAR LAKE			891 FLORENCE STREET VHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	 If still no insuli be blocked. Change If no insulin coneedle, your SoloSi use this SoloStar." The package insert Dispensing Solution directed the provide to ensure the accur to prevent under-do instructions were as KwikPen - Important Prime every tim a stream of insulin I sure the Pen is reade If you do not pri too little insulin. Frequently Asked G Why should I pe dose? Ensures that a of the tip of the nee Knob in. Removes air th insulin cartridge dure What should I of in the Dose Knob w Attach a new Prime the Pen. What should I of in the Dose Knob w Attach a new Prime the Pen. What should I of cartridge? You need Remember, do not attached as this ma in the insulin cartrid 	n comes out, the needle may e the needle and try again. omes out after changing the tar may be damaged. Do not for Lantus SoloStar insulin by ns, Inc. revised on 9/27/12, er/consumer to prime the pen acy of dispensing the insulin osing or overdosing. The s followed: "Priming Humalog nt Notes ne. The Pen must be primed to before each injection to make dy to dose. ime, you may get too much or Questions about Priming rime my KwikPen before each at the Pen is ready to dose. s stream of insulin comes out dle when you push the Dose at may collect in the needle or ring normal use. do if I see an air bubble in the d to prime the Pen. store the Pen with the needle by cause air bubbles to collect ge. A small air bubble will not d you can continue to take	F	333			

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	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		B NO. 0938-039 (3) DATE SURVEY
F CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
	245300	B. WING		07/23/2015
PROVIDER OR SUPPLIER	•			
Y CARE CENTER - V	HITE BEAR LAKE			
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG		
Continued From pa	ge 21	F 33	3	
The facility provided provided by Merwin and 5/27/15. Topics Flex Pen" Instruction Pen Turn the dose Press and hold the drop appears." Rev dated 5/21/15 and 9 indicate RN-B atter	d inservicing information Pharmacy between 5/21/15 included "How to use your ons included "Prepare your selector to select 2 units. dose button. Make sure a riew of attendance sheets 5/27/15, provided did not			
483.35(i) FOOD PF	ROCURE, /SERVE - SANITARY	F 37	1	8/20/15
considered satisfac authorities; and (2) Store, prepare,	tory by Federal, State or local distribute and serve food			
by: Based on observat review the facility fa conditions for ice m for cooking and/or g kitchenettes and ar main kitchen to pre borne illness. This of 135 residents wh	tion, interview and record ailed to maintain sanitary nachines in 3 of 7 kitchenettes, griddle top pans in 6 of 7 n undated food item in the vent the possibility for food had the potential to affect 133 no were served food and/or		 prepared with the compliance of the Federal, State and Local authority regulations to reduce the risk of food borne illness. Corrective action includes the followine 1.) Dietary Manager updated specific 	ng:
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From part The facility provided provided by Merwin and 5/27/15. Topics Flex Pen" Instruction Pen Turn the dose Press and hold the drop appears." Rev dated 5/21/15 and 9 indicate RN-B atter to use a flex pen. 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfact authorities; and (2) Store, prepare, under sanitary cond This REQUIREMEN by: Based on observat review the facility fa conditions for ice m for cooking and/or g kitchenettes and ar main kitchen to pre borne illness. This I of 135 residents wh	IDENTIFICATION NUMBER: 245300 PROVIDER OR SUPPLIER Y CARE CENTER - WHITE BEAR LAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN 245300 B. WING	IF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245300 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE YEAR CENTER - WHITE BEAR LAKE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES PREFIX REACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX RECOLLTORY OR LSC DENTIFYING NFORMATION) PREFIX Continued From page 21 F 333 The facility provided inservicing information provided by Mervin Phramacy between 5/21/15 F 333 Ordop appears, "Review of attendance sheets dated 5/21/15. Topics 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 tindicate RN-B attended inservice training on how to use a flex pen. F 371 STORE/PREPARE/SERVE - SANITARY F 371 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 F 371 This REQUIREMENT is not met as evidenced by: All residents will be served food that prepared withthe compliance of the Federal, State and Local authority regulations to reduce the risk of food borne illness. This had the potential to affect 133 of 13 residents who were served food and/or fluids out of all 7 kitchenettes and the main All res

Event ID:HM6Y11

Facility ID: 00923

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· /	E SURVEY PLETED
				G	COMPLETED	
		245300	B. WING STREET ADDRESS, CITY, STATE, ZIP (07/2	23/2015
NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER - WHITE BEAR LAKE						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 371	12:14 p.m. the follo confirmed by the Ci (CSD-C and CSD-I Cedar Terrace kitch machine was noted heavy lime buildup pan. CSD-C verified cleaned." The gridd inches long by 8 ind all kitchenettes had substance on the ci Rosewood kitchene heavy buildup of a I cooking surface of Gardenview kitcher was noted to be dri on the backsplash a on the inside of the and corners of the of the water that was of CSD-C stated he w been put in.	and facility tour on 7/20/15, at wing was observed and ulinary Services Directors D). henette, the resident ice to be dripping and had a on the backsplash and drip d it was dirty and "should be dle top pan approximately 16 ches wide which was found in a heavy buildup of a black pooking surface of the griddle.	F 37	 routinely complete weekly audits of cleaning lists; audits will be filed for year. 2.)Maintenance technician was brout to fix leaking ice machines. A schedule for deliming ice machine regularly set up. 3.)Dietary managers held training employees to explain information provide staff education on infection issues. Training included a packet employees signed. Issues include A.) Food in coolers without dates a proper labeling. B.) Procedures for cleaning griddl 4.) Audits will be completed by die manager or assigned staff to ensure gulations are being met. 5.) Additional staff education and corrective action will be provided t ensure compliance with regulation needed. 	or one ought es was with and n control t ed: and achines. es. tary ire	
	substance on the contransitional Care U the resident ice ma dripping, had a hea backsplash and drip brown matter on the on the sides and contransition	a heavy buildup of a black booking surface of the griddle. nit (TCU) on the second floor, chine was noted to be vy lime buildup on the p pan as well as a buildup of e inside of the ice shoot and brners of the drip pan. The a heavy buildup of a black				

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				TID:			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245300	B. WING			07/23/2015	
NAME OF	PROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE			·	
				1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 371	Continued From pa	age 23	F 3	371			
	substance on the c CSD-D stated an o	ooking surface of the griddle. utside company was aning the ice machines.					
	7/22/15, at 10:00 a	itchen and kitchenette tour on .m. the following was observed Dietary Director (DD) and					
	thawed frozen rasp cardboard box was approximately a qu surrounding it. The 7/6/15 shipping dat they were unsure o	a ten pound bag (half full) of oberries stored in the original sitting in a pan with arter inch of red juice box was not dated and had a te on it. DD and CSD-D stated of how long the thawed en in the refrigerator.					
	machine was still d a 12 inch cast iron buildup of a black s surfaces. DD stated pans was carbon b When DD scraped	nenette, the resident ice ripping, a griddle top pan and cooking pan had a heavy substance on both cooking d the black substance on the uildup and could not come off. the heavy black substance move it and agreed that it was p on the pans.					
	same size as noted	ette, the griddle top pan the d above had a heavy buildup of on the cooking surface of the					
	Gardenview kitcher was still dripping.	nette, the resident ice machine					
	and a 12 inch cast	chenette, the griddle top pan iron cooking pan had heavy substance on the cooking					

If continuation sheet Page 24 of 40
		AND HUMAN SERVICES				FORM	08/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245300	B. WING			07/3	23/2015
NAME OF I	PROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER - V	VHITE BEAR LAKE			1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ige 24	FS	371			
	surface each pan.						
	machine was still d and a 12 inch cast	the second floor, resident ice ripping, the griddle top pan iron cooking pan had heavy substance on the cooking is.					
		, the griddle top pan had a black substance on the the griddle.					
	iron cooking pan ha	a the first floor, the 12 inch cast ad heavy buildup of a black ooking surface of the pan.					
	food policy dated 3. potential for foodbo will be educated on and storage. It furth items must be in clo	age of Food, use of leftover /11, indicated that due to the orne illness the culinary staff a safe food handling practices her noted "all perishable food osed containers, labeled with is and the date it was					
	cleaning lists for the "wipe down the out drawers, stove top,	ty Days and Nights daily e kitchenettes indicated to side of the cupboards, ice machine/juice machine" and pan, put oil on griddle."					
	indicated the Culina maintained in a clea that cleaning sche- listed, will be provid cleaning tasks com appropriate manne	ed Cleaning Schedules policy, ary Department will be an and sanitary condition and dules, with all cleaning tasks ded in the department and pleted in a timely and r. Each culinary personnel are w their assigned cleaning					

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						0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		245300	B. WING		07/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	Y CARE CENTER -	WHITE BEAR LAKE	-	891 FLORENCE STREET /HITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	Continued From pa	-	F 371			
	responsibilities and work shift.	d to carry them out during their				
	DD stated that EC ice machines in the should be cleaning been that bad. We	on 7/21/15, at 2:00 p.m. the OLAB was responsible to clean e kitchenettes, but dietary staff them daily, "it shouldn't have have had problems with the e got them, they need to be				
F 411 SS=D	DD stated she doe back all of the time verified the last tim the ice machines v	IE/EMERGENCY DENTAL	F 411			9/1/15
		ssist residents in obtaining ur emergency dental care.				
	resource, in accord part, routine and e meet the needs of Medicare resident routine and emerg necessary, assist t appointments; and to and from the de	vide or obtain from an outside dance with §483.75(h) of this mergency dental services to each resident; may charge a an additional amount for ency dental services; must if the resident in making I by arranging for transportation ntist's office; and promptly refer or damaged dentures to a				
	This REQUIREME by: Based on observa	NT is not met as evidenced				

Facility ID: 00923

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		(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	СОМ	PLETED
		245300	B. WING _		07/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ERENI	Y CARE CENTER - W	HITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 411	Continued From pa	ge 26	F 4 ⁻	11		
	review, the facility fa	ailed to provide routine dental		on 7/23/2015		
	services for 1 of 3 residents (R28) reviewed for dental care whose dentures did not fit properly. Findings include:		R28 was offered Dental Service an appointment scheduled for 8			
	R28 was observed have no teeth or de time, R28 stated sh them out during her dentures, R28 state after her admission she was eating just loose and her mout result. The resident's nutrit resident's weight loo dated 7/20/15, indic 134.6#. A nutritional indicated the reside on 1/22/15. The residence numerous factors c	on 7/21/15 at 10:49 a.m. to ntures in her mouth. At that e had dentures but had taken nap. When asked about her ed she'd lost weight before and to the facility and although fine now, the dentures were h was occassionally sore as a tional notes verified the ss. A quarterly nutrition note eated R28's weight was al note dated 1/23/15, nt's weight had been 173.6# sident's record identified ontributing to the weight loss.		All other residents have had documentation reviewed to verif have had an Oral Assessment of within the past 12 months and it were identified on the Oral Asse dental services were offered or was verified and documented. R28 has had her care plan upda reflect current status with her de and reviewed at care conference Clinical Comprehensive Admisss Assessment will be conducted of admissions with in 24 hours. Au be conducted by clinical manag The faciliy policy/procedure rela "Dental Care" was reviewed/rev The Staff have been re-educate expectations related to dental c	completed concerns essment, follow-up ated to entures es. A ion on all diting will ers daily. ted to ised. ed on the	
	dentures/appliance. included, "patient do mouth problems. S stay moist as long a She did say that he little bit." R28's care plan dat required assist of our	" The assessment summary bes not c/o (complain of) the says her lips and mouth as she has water on her table. r upper dentures bother her a ed 4/20/15, indicated R28 he for oral care and that R28 er dentures, but had no		Audits will be completed on all r during their ARD a Comprehens Assessment x3 months to ensu residents have an Oral Assessm completeed per facility policy ar follow - up action required is con and documented, including offe services.	esidents sive re nent nd that any mpleted	

Facility ID: 00923

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY IPLETED
	-	245300	A. BUILDING	G		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07/	23/2015
				1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 411 F 431 SS=E	R28, and RN-F sta R28 had seen a de 1/18/15. RN-F sta find out." During an interview licensed practical in also unaware of de During an interview MDS coordinator (assessment would computer system) if not she would no a dental appointme MDS-B stated "son done after the (1/2 identified loose de During another inte at 1:47 p.m., MDS referrals to a denti dentures for R28. 483.60(b), (d), (e) LABEL/STORE DF The facility must e a licensed pharma of records of recei controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled.	aware of any dental issues for the she was not sure whether entist since her admission on ted, "I will call her daughter to v on 7/23/15, at 12:19 p.m. hurse (LPN)-F stated she was ental issues for R28. v on 7/23/15, at 12:53 p.m. MDS)-B stated normally an oral l be in Matrix (electronic before completing an MDS and otify nursing to complete it, and ent would take place if needed. mething should have been 7/15) oral assessment ntures." erview with MDS-B on 7/23/15 -B verified there had been no st to adjust the ill-fitting DRUG RECORDS, RUGS & BIOLOGICALS mploy or obtain the services of cist who establishes a system pt and disposition of all sufficient detail to enable an ation; and determines that drug er and that an account of all maintained and periodically		further audit needs. The Director of Nursing/designee responsible for maintaining compl Date of Completion: Sept. 1, 2015	iance.	9/1/15

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		AND HUMAN SERVICES				APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
		245300	B. WING		07/	23/2015
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
CERENI	TY CARE CENTER - V	VHITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 431	appropriate access instructions, and th applicable. In accordance with facility must store a locked compartment controls, and perm have access to the The facility must pr permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri	State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can	F 4	31		
	by: Based on observa review the facility fa medications, ensur ensure outdated m for use on 3 of 5 nu medication storage Findings include: Secure Medication On 7/22/15, during			LPN - C was immediately the expectations to secure the cart and lock the cart we unattended. A lock was added to the ref Cedar medication room to medications that require re double-locks. All medication have had capacity to unloch button pad have been remo- now only open using a key.	rigerator in the secure frigeration and on room doors < using a push oved. Doors	

Facility ID: 00923

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PRINTED: 08/21/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039
ID PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
		245300	B. WING		07/2	23/2015
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ERENI	TY CARE CENTER - W	VHITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 431	Continued From pa	ae 29	F 43 [.]	1		
	key lock was obser unlocked position. from the nursing sta pain) for R325 was cart. When interview licensed practical in she had left the car During a random of a.m. the Cedar med observed to be unlo (RN)-C was notified of the medication ro RN-C. In addition t was no lock on the contained a sealed only with a number kit contained 2 vials vials of insulin. RN- room door should a could take it (emerg was working the un key, but had not ch it was unlocked. Review of facility pod dated 2001 (revised "The facility shall s in a safe, secure, a shall not use discor deteriorated drugs Compartments (i drawers, cabinets, and boxes.) contair shall be locked whe	ved to be fully extended in the The cart was located across ation. Voltaren gel (a cream for left unattended on top of the wed on 7/22/15 at 8:56 a.m. urse (LPN)-C acknowledged t open and unattended. oservation on 7/23/15, at 8:02 dication room door was ocked. Registered nurse d of the unlocked door. A tour oom was conducted with o the unlocked door, there medication refrigerator which plastic emergency kit sealed ed plastic tab. The emergency s of Lorazepam 2mg /ml and 2 C stated, "the medication always be locked. Someone gency kit) right out." RN-F who it stated she had just used the ecked the door to see whether blicy for Storage of Medication d 2007) included: store all drugs and biological's nd orderly manner facility ntinued, outdated, or including, but not limited to rooms, refrigerators, carts, ning drugs and biological's	F 43	 rooms were checked for expired medications, and medications that not dated when opened, as require not dated when opened, as require removed/destroyed on 8/20/2015. Nurses received re-education on fapolicies related to checking labels of medication, removal of expired medications, and keeping medicatis secure in a locked medication cart, locked medication room on 9/1/201 Audits will becompleted weekly x 2 months, then monthly for 1 month of medication carts / medications are rer destroyed and all medications are rer destroyed and all medications are rer destroyed and all medication are rer destroyed and all medication room as well as observing for no medication for a swell as observing for no medication room as well as observing for no medication room as well as observing for no medication room as well as observing for no medication room as used and decisions made abor further audits need. Director of Nursing / Designee will I proper funcioning of locks, any malfunction if not working and will r to Maintanence Department for rep Date of Completion : Sept. 1, 2015 	d, were d were d were cilities on on or 5. on all is to noved / abeled for 4 docked ions, tions e QA out lensure report	

STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
			B. WING			
	PROVIDER OR SUPPLIER	245300	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	23/2015
	TY CARE CENTER - V	VHITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 431	On 7/23/15, at 7:30 care unit (TCU) me for medication stora medication used to located in the top d but lacked a prescr be determined to w been dispensed or There were 220 ou insulin dispense per formula plus Zinc (f found in the cart wi The label indicated 1/3/14. A bottle of with vitamin d 400 i dated as opened 7/ expiration date was although no one wa medications, the ep available for use. A was not dated whe was within last 28 of On 07/23/15, at 7:3 of the first floor TCI Stored in the medic undated open vial of testing), dispensed the vial was opener bottle of Cranberry opened 8/22/14, th date was 6/15. RN- taking the cranberr the nurses should f expiration and rem On 7/23/15, at 7:50 the Cyprus Court m	a.m. the first floor transitional edication cart #2 was observed age. A Lantus Solostar pen (a control blood sugar) was rawer of the medication cart, ription label; It was unable to whom the Solostar pen had when it had been dispensed. t of 300 units remaining in the en. A bottle of advanced stress nutritional supplement) was th an expiration date of 3/15. the bottle had beens opened calcium 600 milligrams (mg) iu (international units) was /16/15. The manufacturer's s 5/15. RN-B verified that as currently using these expired medications remained A Lantus Solostar pen for R55 n opened, the dispensed date	F 4:	31		

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
		245300	B. WING _		07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENII	TY CARE CENTER - W	HITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 431	Continued From pa	ge 31	F 43	31		
		plisol. LPN-E, acknowledged				
	•	ed as having been opened red and available for use.				
		nufacturer's insert for Aplisol				
	-	use more than 30 days d due to possible oxidation				
	and degradation wh	nich may affect potency."				
F 441 SS=E	483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F 44	41		9/1/15
22=E	SI NEAD, EINENS					
		tablish and maintain an				
		ogram designed to provide a comfortable environment and				
		development and transmission				
	(a) Infection Contro	l Program tablish an Infection Control				
	Program under whi	ch it -				
	 Investigates, co in the facility; 	ntrols, and prevents infections				
		ocedures, such as isolation,				
		o an individual resident; and				
	actions related to in	ord of incidents and corrective fections.				
	(b) Preventing Spre					
		ion Control Program esident needs isolation to				
	prevent the spread	of infection, the facility must				
	isolate the resident.	t prohibit employees with a				
	communicable dise	ase or infected skin lesions				
		with residents or their food, if				
	direct contact will tr (3) The facility mus	ansmit the disease. t require staff to wash their				
	hands after each di	rect resident contact for which				

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		AND HUMAN SERVICES				PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245300	B. WING			07/23/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•
CERENII	TY CARE CENTER - W	VHITE BEAR LAKE		18 W		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 441	Continued From pa	ige 32	F4	441		
	hand washing is inc professional practic	dicated by accepted ce.				
		ndle, store, process and as to prevent the spread of				
	by: Based on observat review, the facility fi infection control me cares for 2 of 3 resi incontinence. In ac ensure that clean lin and sanitary manne	NT is not met as evidenced tion, interview and document ailed to ensure appropriate easures were used during idents (R92, R19) reviewed for ddition, the facility failed to nens were stored in a clean er; and failed to ensure iene was performed during			NA - B and NA - E were immediat re-educated on the facilities policy regarding washing hands and cha gloves when providing care for res NA - D was immediately re-educat the expectations of hand washing including how to manage hand was when wearing a splint.	, inging sidents. ted on , ishing
	During continuous of 8:30 a.m. to 9:08 a. was observed to as Supplies had been wearing gloves, NA pericare to R92. NA wipes, four times, to was soiled. At 8:35 cream was going to thighs/buttocks and the cream the exce gloves with a wash on the floor by the r R92 that she was g	observations, on 7/22/15 at .m., nursing assistant (NA)-B sist R92 with morning cares. set up at the bedside and, a-B proceded to perform A-B used several clean wet o clean R92's bottom, which a.m., NA-B informed R92 that o be applied between R92's after NA-B finished applying ss cream was wiped off the cloth and the cloth was thrown hight stand. NA-B informed loing to put the incontinent pad R92's socks and pants. NA-B,			Staff received re-education on the Infection Control Policy/Procedure including proper hand washing an gloving. Dining Room audits will b completed on the same schedule ensure infection control practices followed during resident meal serv Clean linen storage areas will be a on the same schedule to ensure p items are not stored in the clean li areas. Audits will be reviewed by QA/IDT and determine if further education action plans need impletation. The Director of Nursing / Designe	es d be to are <i>v</i> ice. auditied bersonal nen

Facility ID: 00923

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TATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245300	B. WING	d			
		245300	D. WING			/23/2015	
	PROVIDER OR SUPPLIER	WHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP COL 1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 441	with the same glov pericare, used ano wipe R92's face. N going to remove R the gown threw it of patted dry R92's un apply deodorant, h deoderant. Still we rolled R92, in bed, R92's shirt. NA-B t to help R92 up. At linen off the floor a bottom drawer of th graduate cylinder t Foley bag and disp NA-B rinsed the cy towels and placed bedside stand. Sup earlier were put ba the bedside stand. Sup earlier were put ba the gloves but neve a.m., NA-A asked to roommate out of b NA-B went over to using a Hoyer lift m sheet to the Hoyer assistance transfer was observed to ta side of the bed and was attached to the using bare hands. R92, informed R92 brush teeth and wi donned a pair of gl and told R92 she v	es that were used to provide ther clean wet wash cloth to A-B told R92 that she was 92's gown and after removing in the floor. NA-B washed and inderarms and attempted to owever R92 refused the aring the same gloves, NA-B towards the wall and adjusted hen asked NA-A for assistance 8:48 a.m., NA-B picked the ind bagged it, opened the ne bedside stand to obtain a o empty the urine out of R92's posed of the urine in the toilet. linder, dried it with paper it in the bottom drawer of the oplies that had been used ck in the other two drawers of At 8:59 a.m., NA-B removed er washed her hands. At 9:00 for assistance to help R92's ed. Without washing hands, help transfer the roommate, nachine. NA-B attached the lift hooks and with NA-A's rred R92. At 9:05 a.m., NA-B tke the catheter bag off the d put it inside a cloth bag that e side of R92's wheelchair, NA-B then put a sweater on that she would assist her to thout washing hands, NA-B oves, set the tooth brush up vas going to leave the room to A-B removed gloves and	F 44	1 reponsible for maintaining cor Date of Completion Sept. 1, 2			

Facility ID: 00923

If continuation sheet Page 34 of 40

TATEMEN	F OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION	· /	TE SURVEY MPLETED	
		245300	B. WING		07	07/23/2015	
	PROVIDER OR SUPPLIER	VHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 441	gloves, brushed RS bathroom to rinse to the gloves and ass When finished NA- breakfast" and whe After NA-B had sta asked R92 what sh walking towards the 9:10 a.m., NA-B wa acknowledged she after removing glov gloves after providi asked what the fac stated "I usually do am done and gettir asked if she was sh after performing per we have not been to On 7/22/15, at 9:19 was interviewed an supposed to chang providing pericare a resident. On 7/22/15, at 9:30 regarding gloving a explained that her change gloves and pericares to chang before continuour from 7:57 a.m. to 8 to assist R19 with r washing hands, NA picked up the fall m	92's teeth and went to the he tooth brush. NA-B removed isted R92 to brush her hair. B stated, "let's get you some eeled R92 into the dining room. tioned R92's wheelchair, NA-B ne wanted to drink and started e beverage cart. At this time, as interviewed and had not washed her hands ves and had not changed ng R92 pericare. NA-B was ility policy was and NA-B not remove my gloves until I ng the linen, like I did." When upposed to change gloves pricare NA-B stated, "I guess	F 4	41			

If continuation sheet Page 35 of 40

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245300	B. WING	i		07/23/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER - V	VHITE BEAR LAKE			1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 441	assisted her to get ambulated R19 to to NA-E took off R19's in the trash can and the toilet. NA-E cow body with her night R19, filled a basin we clean washcloths of gave one wet wash face, then a dry tow clean incontinent por R19's legs while R ⁻¹ toilet. With the sam touched the bottom them off R19, went handles, got a anot put on R19's legs, j product, put both si bottom of the shoes then took off her gle that was covering F without washing he washcloth with soa her arms. NA-E ass underarms, put on same gloved hands pearls on R19 and went to get a tooth from the top drawe brushed R19's top placed them on the clean paper towel, paste on the brush brushed her bottom spit in a container N right hand was rest she waited for R19	A-E took off R19's tabs alarm, up on the side of the bed,and he toilet in the bathroom. s incontinent product, placed it d assisted R19 to sit down on rered R19's bottom half of gown, took the transfer belt off with warm water, placed two n the side of the wash basin, icloth to R19 who washed her vel to wipe her face, and put a roduct around the bottom of 19 was still sitting down on the re gloved hands, NA-E of both shoes, while taking to the closet, touched closet ther pair of jeans which were ust below the incontinent hoes back on, touching the s, and tied the laces. NA-E by the side of the night gown R19, put new gloves on, r hands, gave another wet p to R19 who washed under sisted R19 to dry her deodorant and lotion with the s. NA-E then put on a shirt and combed R19's hair. NA-E then brush, toothpaste and dentures r, situated next to the sink, dentures with toothpaste, a right side of the sink on a got another toothbrush, put and gave it to R19 who n teeth, swished with water and NA-E was holding. NA-E's ing on the edge of the sink as to finish. NA-E rinsed R19's in a container. NA-E then		441			

Facility ID: 00923

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TATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		DENTRIORITORITORIDER.	A. BUILDIN	G			
		245300	B. WING			7/23/2015	
	PROVIDER OR SUPPLIER	WHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP COD 1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 441	NA-E put paper tow the transfer belt on towels in a plastic k of the resident and put them on. NA-E hands, put new glo wet washcloth and front to back, folde from front to back, folde from front to back, pad up, then R19's wash hands and as her wheelchair situ NA-E hooked up th wheelchair, brough NA-E then went to the nursing station a paper plate, but t the nursing station a few minutes, NA- adjoining dining roo door and opened it time, 8:30 a.m., an washed her hands will usually wash ha out, "I know I forgo she had not proper tasks. During an interview RN-F stated hands glove changes, bef leaving a resident's touched, before yo between top and bu	denture who put it in her mouth. wels in the trash bag, placed the resident, placed the bag, placed the walker in front handed glasses to R19, who took off gloves, did not wash wes on, obtained a different washed R19's peri-area from d the washcloth, again washed NA-E pulled the incontinent pants, took off gloves, did not ssisted R19 using her walker to ated outside the room door. he tabs alarm on the tt R19 out to the dayroom. the pastry container situated at , used tongs to put a muffin on hen went to the closet next to to talk with another aide. After E turned and went to the om, touched the refrigerator . NA-E was interviewed at this d stated she should have after washing R19's face and ands after taking the dirty linen t." NA-E acknowledged that ty washed her hands between fore going in and before s room, anytime the face is u handle any food and anytime	F 44				

If continuation sheet Page 37 of 40

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	TPLE CONSTRUCTION). 0938-039 TE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	· · /	MPLETED		
		245300	B. WING _			/23/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E			
CERENI	TY CARE CENTER - V	VHITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 441	Continued From pa	age 37	F 44	41				
		pericares,"I always say if in						
	Unit (TCU), on 7/20 linen door was ope linen cart was visib cover over the liner personal blue greet and lighter in the po a banana on top of At 12:43 p.m. RN- usually kept shut at staff personal items	B explained that the door was nd that it was unusual to have s there, referring to the lighter -B closed the door, however,						
	dining room on 7/2 wash hands upon e before delivering pl noted to have a rigi to be made of hard a Velcro strap arou At 5:34 p.m., NA-D resident's wheel ch passed coffee to an brought R41 her su fingers of the unglo prepare the ribs for observed to wash t At 5:43 p.m. NA-D dining room and up	observation in the Cedar 0/15 at 4:43 p.m., NA-D did not entering the dining room or lates to residents. NA-D was ht hand splint which appeared plastic around two fingers and nd the right hand. was observed to push a hair up to the table and then nother resident. NA-D then upper plate and used three by dright splinted hand to r R41 to eat. NA-D was he fingers of her right hand. wheeled a resident out of the boon return did not wash hands d plates to residents.						
	observed to wash t At 5:43 p.m. NA-D dining room and up before passing food At 6:10 p.m., NA-D hands and did rem	he fingers of her right hand. wheeled a resident out of the oon return did not wash hands						

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		AND HUMAN SERVICES				FORM	: 08/21/2015 1 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		245300	B. WING			07	/23/2015
NAME OF F	PROVIDER OR SUPPLIER		· [TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CERENIT	TY CARE CENTER - V	VHITE BEAR LAKE			891 FLORENCE STREET VHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	Continued From pa splint."	age 38	F 4	41			
	member has a splir them to remove it if	p.m., DON stated "If a staff nt on their hand I would expect f able and wash as normal, a glove to cover the splint					
	(DON) stated staff hygiene, change gl	7 p.m., the director of nursing were supposed to do hand oves between residents, after and follow the hand hygiene					
	August 2012, direc "5. Employees mus fifteen (15) second non-antimicrobial s following conditions	st wash their hands for at least s using antimicrobial or oap and water under the s:					
	washing with soap c. Before and after which hand hygiene professional practic	are visibly soiled (hand and water); direct resident contact (for e is indicated by acceptable					
	procedure (e.g. fing sampling);	gerstick blood					
	f. Before and a washing with soap	fter or handling food (hand					
	personal care (e.g. i. Before and a	after assisting a resident with oral care, bathing); fter handling peripheral nd other invasive devices;					

If continuation sheet Page 39 of 40

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245300	B. WING		07	/23/2015
				STREET ADDRESS, CITY, STATE, ZIP CODE 1891 FLORENCE STREET		
EKENI	TY CARE CENTER - V			WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 441	catheters; k. Before and a l. Upon and after co resident's intact ski or blood pressure, a m. After persor washing with soap n. Before and a toileting (hand wash water); o. After contact with diarrhea including, caused by noroviru difficile (hand wash p. After blowing q. After contact membranes and bo r. After blowing dressings, bedpans s. After handling dressings, bedpans s. After handling t. After perform (hand washing with u. After removin v. After comple 7. Hand hygiene is removing and dispo equipment. 8. The use of glove handwashing/hand Assistance with me 2013, directed: "7. All employees w assistance with me demonstrate compo	fter inserting indwelling after changing a dressing; pming in contact with a n, (e.g., when taking a pulse and lifting a resident); hal use of the toilet (hand and water); after assisting a resident with hing with soap and n a resident with infectious but not limited to infections s, salmonella, shigella and C. ing with soap and water); g or wiping nose; t with a resident's mucous bdy fluids or excretions; g soiled or used linens, s, catheters and urinals; g soiled equipment or utensils; ing your personal hygiene a soap and water); ng gloves or aprons; and ting duty always the final step after psing of personal protective s does not replace hygiene" eals policy revised September who provide resident als will be trained and shall etency in the prevention of ncluding personal hygiene	F 44			

If continuation sheet Page 40 of 40

		AND HUMAN SERVICES	PS	30	1025		APPROVED
		& MEDICAID SERVICES			and the second	T	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01	COM	IPLETED
			/				
		245300	B. WING			07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 91 FLORENCE STREET		
CERENIT	TY CARE CENTER - W	VHITE BEAR LAKE			HITE BEAR LAKE, MN 55110		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE RIATE	COMPLETION DATE
170		· · · · · · · · · · · · · · · · · · ·			DEFICIENCY)		
			14.0				
K 000	INITIAL COMMENT	IS	К0	000			
	FIRE SAFETY						
		OC WILL SERVE AS YOUR					
		COMPLIANCE UPON THE					
		CCEPTANCE. YOUR					1.1.1
		HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS					
	VERIFICATION OF						1 ± 1 x
		F AN ACCEPTABLE POC, AN					
		OF YOUR FACILITY MAY BE					
	CONDUCTED TO						
		MPLIANCE WITH THE AS BEEN ATTAINED IN					
		ITH YOUR VERIFICATION.					
	A Life Safety Code	Survey was conducted by the					
		nent of Public Safety. At the					
5		Cerenity Care Center White					
		nd not in substantial e requirements for participation					
	in Medicare/Medica	aid at 42 CFR, Subpart					
		ety from Fire, and the 2000				-	
		Fire Protection Association 01, Life Safety Code (LSC),					
	Chapter 19 Existing	•					
	PLEASE RETURN	THE PLAN OF			EPOC		
	CORRECTION FO	R THE FIRE SAFETY					
	DEFICIENCIES (K	(-TAGS) TO:					
	HEALTHCARE FIR	E INSPECTIONS					
	STATE FIRE MARS	SHAL DIVISION					
	445 MINNESOTA ST. PAUL, MN 551	STREET, SUITE 145 01-5145					
	07. 17.02, MIX 001						
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	nically 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.

Alter Alter

PRINTED: 08/27/2015

	EDICALD SERVICES			0	MB NO.	APPROVED 0938-0391
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
	245300	B. WING			07/2	23/2015
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 891 FLORENCE STREET		
CERENITY CARE CENTER - WHITE	E BEAR LAKE			WHITE BEAR LAKE, MN 55110		
PREFIX (EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
to correct the deficiency. 2. The actual, or propose 3. The name and/or title responsible for correction prevent a reoccurrence of Cerenity Care Center W 2-story building with notic was constructed at 3 diffind building was constructed determined to be of Type 1974, addition was const that was determined to be construction. In 1983, and constructed to the West determined to be of Type Because the original building are of the same type of of construction type allowed the facility was surveyed a 2 story addition was const Because the original building of 2 different construction surveyed as two separate The building is fully fire separate	mn.us and tate.mn.us CTION FOR EACH CLUDE ALL OF THE ATION: has been, or will be, done done done done done done done done	κo	000			

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Facility ID: 00923

If continuation sheet Page 2 of 6

PRINTED: 08/27/2015

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
ID PLAN U	F CORRECTION	DENTIFICATION NOWDER.	A. BUILDIN	IG 01 - MAIN BUILDING 01		
		245300	B. WING		07/2	23/2015
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1891 FLORENCE STREET		
ERENIT	TY CARE CENTER - V	HITE BEAR LAKE		WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
K 000	that is monitored fo notification. The fac	ge 2 r automatic fire department cility has a capacity of 178 nsus of 138 at the time of the	K OC	00		
	Surveyor that the fi resident rooms is a unobstructed cover	on of this Life Safety Code re sprinkler coverage in the adequate to provide complete age to the exterior of the accordance with NFPA 13 2-05-38, A1.				
K 025 SS=E	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 02	25		8/20/15
33-E	least a one half hou accordance with 8. terminate at an atri protected by fire-ra panels and steel fra separate compartm floor. Dampers are penetrations of smo	e constructed to provide at ar fire resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass ames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted , and air conditioning systems. 19.1.6.3, 19.1.6.4				
	Based on observa maintain the smoke the requirements o Sections 19.3.7, 19 This deficient pract	s not met as evidenced by: tion, the facility failed to barrier in accordance with f NFPA 101 - 2000 edition, 0.3.7.3, 8.3, 8.3.2 and 8.3.6. ice could affect all residents, thin the smoke compartments.		Maintenance personnel adjusted hinges on door to achieve proper of door, completed 7/24/15 All fire doors will be monitored for of proper closing during fire drills month.	closing failure	

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Facility ID: 00923

If continuation sheet Page 3 of 6

DEFMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION		E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			1 - MAIN BUILDING 01	СОМ	PLETED
		245300	B. WING			07/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER		_		REET ADDRESS, CITY, STATE, ZIP CODE		
CERENII	TY CARE CENTER - W	/HITE BEAR LAKE			91 FLORENCE STREET HITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
K 025	Continued From pa	ge 3	K 02	25			
	Findings include:	and 02:00 DM			Credible allegation of compliance	7/24/15	
	on 07/23/2015, it w	veen 09:00 AM and 02:00 PM as observed that the smoke om 1200 did not full close			Maintenance director or designate person will be responsible for audi reporting any discrepancies; to the committee.	ting and	
		verified by Director of vice (JH) at the time of					
K 029 SS=F	NFPA 101 LIFE SA	FETY CODE STANDARD	K 02	29			8/20/15
	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro- the approved autom option is used, the other spaces by sm doors. Doors are s field-applied protect	construction (with ³ / ₄ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from toke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are					
	Based on observat failed to provide pro accordance with the -2000 edition, Secti Findings include: On facility tour betw	s not met as evidenced by: tion and interview, the facility otection of hazardous areas in e requirements of NFPA 101 on 19.3.2.1 and 8.4.1 ween 09:00 AM and 02:00 PM as observed that vacated			Maintenance staff installed door of on room 1301, 1303. Rooms 1312, 1313, 1314, 1315, 1 have had all items removed and d have now been locked and mainten has the only key to open doors, to any other department from using t rooms as storage. Completed 8/11	317, oors nance prevent hese	

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Facility ID: 00923

If continuation sheet Page 4 of 6

and the second se	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION (X	3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	COMPLETED
		245300	B, WING		07/23/2015
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ERENII	Y CARE CENTER - W	VHITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC TE DATE
K 029	Continued From pa	ge 4	K 02	9	
	following locations: 1312, 1313, 1314,	1st floor rooms 1301, 1303, 1314, 1315, 1316, 1317.		Maintenance Director or designated person will enter rooms quarterly to in	sure
	of Envirronmental S discovery.	verified by the facility Director Services (JH) at the time of		rooms remain unused as storage.	0/201/-
K 062 SS=D		FETY CODE STANDARD	K 06	2	8/20/15
F C C F	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				
		s not met as evidenced by: ion, record review and		Olsen fire and sprinkler co. will repair	-
	interview the compl system is not being with NFPA 25(99) S	ete automatic fire sprinkler maintained in accordance section 9.2.7. This deficient		head on first floor employee break roo completed by 9/1/15.	
	if the system were t	all occupants of the building to fail under fire conditions.		Olsen fire and sprinkler co. repaired sprinkler head in freezer and applied proper insulator around piping to prev	rent
	07-23-2015, it was	veen 9:00 AM and 2:00 PM on observed that: ad in the 1st floor employee		any further icing up of that area ** credible allegation of compliance 9/1/	15
	breakroom was not head.	operable due to plaster on the		To insure sprinkler heads and fire ala system are in proper order maintenar director or designated person will revi	nce
	walkin freezer was	covered with ice.		fire alarm and sprinkler head inspecti reports semi annually and annually.	
		verified by Director of vice (JH) at the time of		Any new construction will be will be completed within fire code standards review by maintenance director.	and
K 076		FETY CODE STANDARD	K 07		8/20/15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(* .= /	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245300	B. WING		07/23/2015
	PROVIDER OR SUPPLIER	WHITE BEAR LAKE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1891 FLORENCE STREET	
				WHITE BEAR LAKE, MN 55110 PROVIDER'S PLAN OF CORRECTI	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLET
K 076 SS=D	Continued From pa	age 5	K 076		
		e and administration areas are lance with NFPA 99, Standards cilities.			
	(a) Oxygen storage 3,000 cu.ft. are end separation.	e locations of greater than closed by a one-hour			
		upply systems of greater than nted to the outside. NFPA 99			
	Based on observa was not stored in a Standards for Heal This deficient pract residents, visitors a compartment.	is not met as evidenced by: tion and interview,medical gas accordance with NFPA 99, thcare Facilities. tice could negatively impact all and staff within the smoke		Maintenance staff installed hook chain to secure canisters in place Completed 8/13/15 Nursing staff were educated on th importance and proper way to sa O2 containers.	e. he
	07-23-2015, it was The Oxygen Storag had an oxygen bot secured in its hold	ge room located by room 1113 tle on the flor that was not		Maintenance Director or designation person will insure O2 rooms are abeing used. O2 rooms will be monitored by satisfy the committee monthly or more often	safely afety
		vice (JH) at the time of		necessary. Credible allegation of compliance	8/13/15

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

Facility ID: 00923

If continuation sheet Page 6 of 6

PRINTED: 08/27/2015

		AND HUMAN SERVICES	-63	00	2	FORM	08/27/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - 2013 ADDITION		E SURVEY PLETED
		245300	B. WING			07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENII	Y CARE CENTER - W	VHITE BEAR LAKE			391 FLORENCE STREET /HITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	ĸ	000			
	FIRE SAFETY			ĸ			
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm time of this survey, Bear Lake was four compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I	Survey was conducted by the nent of Public Safety. At the Cerenity Care Center White nd not in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.			EPOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
	HEALTHCARE FIR STATE FIRE MARS 445 MINNESOTA ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically 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.

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		AND HUMAN SERVICES	2			FO	RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3)	DATE SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	ING 0 2	2 - 2013 ADDITION		JOWPLETED
		245300	B. WING				07/23/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CO 91 FLORENCE STREET	DE	
CERENIT	Y CARE CENTER - W	HITE BEAR LAKE			HITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
κ οοο	Or by email to: Marian. Whitney@si Angela. Kappenmar THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficient 2. The actual, or pro- 3. The name and/or responsible for corre- prevent a reoccurrent Cerenity Care Cent 2-story building with was constructed at building was constru- determined to be of 1974, addition was that was determined construction. In 198 constructed to the v determined to be of Because the origina are of the same typ construction type all the facility was surv a 2 story addition w Because the origina of 2 different constru- surveyed as two se	tate.mn.us and @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. er White Bear Lake is a n no basement. The building 3 different times. The original ucted in 1957 and was f Type II(222) construction. In constructed to the West Wing d to be of Type II(222) 33, another addition was Vest Wing that was f Type II (222) construction. al building and the 2 additions e of construction and meet the lowed for existing buildings, reyed as one building. In 2013, ras constructed to the West. al building and the addition are ruction codes the facility was	KO				
	has a fire alarm sys	stem with smoke detection in baces open to the corridors					

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Facility ID: 00923

If continuation sheet Page 2 of 6

PRINTED: 08/27/2015

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF		
ND PLAN C		IDENTIFICATION NUMBER:	A. BUILDING 02 - 2013 ADDITION		OMPLETED
		245300	B. WING	0	7/23/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CERENII	Y CARE CENTER - W	HITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 000 K 011 SS=E	that is monitored fo notification. The fac beds and had a cer survey. It is the determinati Surveyor that the fin resident rooms is a unobstructed cover wardrobe closets in (99) and CMS S&C The requirement at NOT MET as evide NFPA 101 LIFE SA If the building has a nonconforming buil barrier having at lea rating constructed o addition. Communi corridors and are pa	r automatic fire department ility has a capacity of 178 hous of 138 at the time of the on of this Life Safety Code re sprinkler coverage in the adequate to provide complete age to the exterior of the accordance with NFPA 13 -05-38, A1. 42 CFR, Subpart 483.70(a) is	К 000 К 01		8/20/15
	Based on observat has failed to mainta the required location by approved self-clo 18.1.1.4.2	s not met as evidenced by: ion and interview, the facility in the 2-hour fire separation at on. corridors and are protected osing fire doors. 18.1.1.4.1,		Maintenance personnel adjusted latch of 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.	
	07/23/2015, it was	veen 9:00 AM and 2:00 PM on observed that the 2-hour fire d not operate as required in		Employees will monitor proper fire door functioning during monthly fire alarm dri and report any non-functioning doors to maintenance; maintenance will repair ar	

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Event ID: HM6Y21

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Facility ID: 00923

If continuation sheet Page 3 of 6

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 - 2013 ADDITION			PLETED
		245300	B. WING		07/:	23/2015
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER - V	HITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
K 011	Continued From pa the following location	-	K 01	1 non- functioning doors as neede	d.	
	 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 			Maintenance will do individual fir inspections quarterly and audit for nonfunctioning doors		
	latch.			Credible allegation of complianc	e 7/24/15	
	This deficiency was Environmental Serviscovery.	s verified by Director of vice (JH) at the time of		Maintenance director or designa will insure correction and monito insure deficiency does not reocc	ring to	
	NFPA 101 LIFE SA	FETY CODE STANDARD	K 02	-		8/20/15
K 025 SS=E	least a one-hour fir accordance with 8. terminate at an atri protected by fire-ra panels in approved separate compartm floor. Dampers are penetrations of smo	e constructed to provide at e resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass frames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted and air conditioning systems. 18.1.6.3	-	1 E MR MR Hart Ration		
				K.e.		
	Based on observa maintain the smoke the requirements o Sections 19.3.7, 19 This deficient pract	s not met as evidenced by: tion, the facility failed to barrier in accordance with f NFPA 101 - 2000 edition, 0.3.7.3, 8.3, 8.3.2 and 8.3.6. ice could affect all residents, thin the smoke compartments.		Maintenance personnel adjuste hinges on door to achieve prope of door, completed 7/24/2015. All fire doors will be monitored b maintenance staff for failure of p closing during fire drills each mo	er closing y proper	

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Facility ID: 00923

If continuation sheet Page 4 of 6

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		E SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 - 2013 ADDITION		COMPLETED	
		245300	B. WING		07/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	Y CARE CENTER - W	VHITE BEAR LAKE		1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 025 K 029 SS=D	Findings include: On facility tour betw on 07/23/2015, it we barrier boors by Sp when tested. This deficiency was Environmental Serv discovery.	ge 4 veen 09:00 AM and 02:00 PM as observed that the smoke eech Therapy did not full close s verified by Director of vice (JH) at the time of FETY CODE STANDARD	K 029	 adjusted as needed. Credible allegation of compliance 7 Maintenance director or designated will audit quarterly to insure the corr and monitoring of door closures and prevent the reoccurrence of this deficiency. 	d staff rection	8/20/15
	with 8.4. The areas fire-rated barrier, w					
	Based on observat failed to provide pro accordance with the -2000 edition, Secti Findings include: On facility tour betwo on 07/23/2015, it wa 1) The 1st floor So self close into the fr 2) The 1st floor Uti close into the frame This deficiency was	biled Linen Room 118 did not ame when tested. lity Room 1118 did not self		Maintenance personnel adjusted of closer on room 1118 for proper clos 7/27/15 Maintenance personnel adjusted d closure on room 118 (soiled linen) proper closure 7/27/15 Quarterly, all self-closing doors will audited by maintenance staff to ins proper closer and functioning. Any doors that are not functioning properly will be reported to the maintenance staff for repair	sing oor for be	

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Facility ID: 00923

If continuation sheet Page 5 of 6

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		AND HUMAN SERVICES			F	FORM A	08/27/2015 PPROVED)938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X 02 - 2013 ADDITION	(3) DATE COMPI	SURVEY LETED
		245300	B. WING			07/2	3/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	TY CARE CENTER - V	VHITE BEAR LAKE			891 FLORENCE STREET VHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 029	Continued From pa	ige 5	к	029			
					closer audit		
					Cedible allegation of compliance 7/24	4/15	
					Maintenance director or designated personnel are responsible for correct and monitoring to prevent this deficie from reoccurring.	tion ency	
						3	
		Obselate Event ID: HMG			sility ID: 00923	ion chool	Page 6 of 6

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Facility ID: 00923

If continuation sheet Page 6



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

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

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

Cerenity Care Center - White Bear Lake August 11, 2015 Page 2

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,

de Comston

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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:	·		
		00923	B. WING		07/2	3/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CEBENII	Y CARE CENTER - V	VHITE BEAR LAK 1891 FLO	RENCE STR	IEET		
		WHITE BI	EAR LAKE, I			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correputsuant to a surver found that the defice herein are not corrected shall with a schedule of the the Minnesota Deput Determination of wit corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnesota Do	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for I Homes.	oftware. to	
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

08/20/15

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If continuation sheet 1 of 49

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
	00923		B. WING		07/23	3/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
ERENI	TY CARE CENTER - V	VHITE REAR I AK	DRENCE STR EAR LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On July 20, 21, 22 this Department's s and the following cor Please indicate in y correction that you and identify the dat Minnesota Department the State Licensing federal software. Ta assigned to Minnes	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. , and 23, 2015 surveyors of staff, visited the above provider prection orders are issued. your electronic plan of have reviewed these orders, e when they will be completed nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for		The assigned tag number far left column entitled "IE The state statute/rule num corresponding text of the out of compliance is listed "Summary Statement of E column and replaces the ' portion of the correction o column also includes the are in violation of the state statement, "This Rule is n evidenced by." Following findings are the Suggeste Correction and the Time F Correction. PLEASE DISREGARD TH THE FOURTH COLUMN STATES, "PROVIDER'S F CORRECTION." THIS AP FEDERAL DEFICIENCIES	D Prefix Tag." aber and the state statute/rule in the Deficiencies" 'To Comply" rder. This findings which e statute after the ot met as the surveyors d Method of Period For HE HEADING OF WHICH PLAN OF 'PLIES TO S ONLY. THIS	
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follor are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	tag number appears in the far left d "ID Prefix Tag." The state ut of compliance is listed in the atement of Deficiencies" column the "To Comply" portion of the er. This column also includes the n are in violation of the state statute ment, "This Rule is not met as Following the surveyors findings ested Method of Correction and		WILL APPEAR ON EACH THERE IS NO REQUIRE SUBMIT A PLAN OF COF VIOLATIONS OF MINNE STATUTES/RULES.	MENT TO RECTION FOR	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
	00923		B. WING	07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
CERENIT	Y CARE CENTER - W		DRENCE STI BEAR LAKE,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 430	MN Rule 4658.0210) Subp. 1 Room Assignments	2 430		9/1/15
	A nursing home miresident's preference	ssignments and furnishings. Ust attempt to accommodate a ces on room assignments, rnishings whenever possible.	ı		
	This MN Requireme	ent is not met as evidenced			
	Based on observati review, the facility fa within reach for use	on, interview and document ailed to ensure call lights were for 3 of 4 residents (R378,		The Facility policy/procedure title : "Answering Call Light" was reviewed on : 9/1/2015	
	for assistance from	ed who utilized their call lights staff.		Staff have been re-educated on the policy/procedure for ensuring call lights	
	Findings include:			are within reach for residents use. 9/1/2015	
	p.m., R378's call lig around the right gra seated in a recliner room, on the oppos recliner was recline	with R378 on 7/20/15 at 6:23 ht was observed wrapped b bar on the bed. R378 was on the other corner of the ite side of the bed. R378's d back. When asked if she		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	e
		call light R378 stated "yes." 0/15, R378 was heard from		improvement. The Audit results will be reviewed by the	
	the hallway calling of her hands. R378 wa	but "help, help" as she waved as still seated in the recliner in all light remained out of		QA committee and decisions made about further audit needs.	
	reach. When the su needed, R378 state	rveyor asked what R378 ed she wanted to go to the elp. The surveyor summoned		The Director of Nursing/designee is responsible to maintain compliance. Date of Completion: Sept. 1, 2015	

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		00923	B. WING	B. WING		23/2015
NAME OF F	PROVIDER OR SUPPLIER					
CERENIT	TY CARE CENTER - V	ΝΗΙΤΕ ΒΕΔΒΙΔΚ	ORENCE STRI BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 430	Continued From pa	age 3	2 430			
	facility visiting and R378 without inforr During this observa able to use the call	s son had just been at the it appeared he had transferred ming staff when he'd left. ation, NA-C verified R378 was light. 20/15, registered nurse (RN)-B				
	also stated R378 w call light. RN-B stat	vas cognitively able to use the ted she would have expected '8's call light was within reach.				
	7/17/15, identified t include: nonorganic tract infection, ence function and acute Individual Resident indicated R378 was	dmission Record sheet dated the resident's diagnoses to c psychosis, confusion, urinary ephalopathy, impaired renal kidney failure. R378's t Care Plan dated 7/17/15, s at risk for falls and also s continent but required staff eting.				
	(DON) stated staff	43 p.m. the director of nursing were to make sure resident hin reach every time staff was m.				
	seated in her whee her bed, with the te closed but opened At the time of obse pants. When appro- sitting here waiting call light was obser coiled at the foot of feet behind and to she was able to us	on 7/20/15, at 6:48 p.m. to be elchair located near the foot of elevision on. R38's eyes were quickly when called by name. wrvation R38 wore a gown and bached R38 stated, "I am for staff to put me to bed." The rved to be out of R38's reach, f the bed, approximately two the right of R38. When asked is e the call light when it was	9			
nesota D		tated, "I can use the call light it is in reach; I get tired of				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
00923		00923	B. WING		07/	//23/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ERENI	TY CARE CENTER - \	ΝΗΙΤΕ ΒΕΔΒΙΔΚ	ORENCE STRE BEAR LAKE, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 430	Continued From pa	age 4	2 430				
	(LPN)-D acknowled within reach. LPN- use call light, "som sometimes she wil here, she had it (ca	D p.m. licensed practical nurse dged R38's call light was not D stated, she does not always etimes she will use it; I just call out. When I left her all light) in her lap. The aides it when they pulled the covers					
	diagnoses included	s, congestive heart failure, and	I				
	5/5/15, indicated R communicate need	ea Assessments (CAA) dated 38 was alert and able to ds to staffContinue to to request assistance."					
		g Assistant Care Sheet ht in reach (sic) @ [at] all					
	R264's call light co at the end of the be	ns on 7/20/15, at 3:55 p.m., rd was observed on the floor, ed. When interviewed, R264 ed the call light but could not					
		sessment MDS dated 5/20/15 gnitive status as 14/15.					
	revised October 20 resident is in bed o	, Answering the Call Light 010, directed "5. When the or confined to a chair be sure in easy reach of the resident."					
		THOD OF CORRECTION: director of nursing or designee)				

STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
	00923		B. WING		7/23/2015
	PROVIDER OR SUPPLIER	HITE BEAR LAK 1891 FLO	DRESS, CITY, RENCE STF EAR LAKE,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 430	could assure that per revised, up to date, to assure resident of that residents need TIME PERIOD FOF (21) days.	olicies and procedures are implemented and monitored call lights are within reach and s are met. R CORRECTION: Twenty-One	2 430		
2 303	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565		9/1/15
	by: Based on observati review, the facility fa for 1 of 3 residents risk for aspiration d Findings include: On 7/22/15, at 12:1 seated in the dining drinking independed be in the DR at that a bite of pureed cor the registered dietic towards the Cedar of medication aide (TM past towards the Cy R92 took another b of nursing (DON) at	ent is not met as evidenced on, interview and document ailed to follow the plan of care (R92) reviewed who was at uring meals. 0 p.m. R92 was observed room (DR) eating and htly, no staff were observed to time. At 12:11 p.m. R92 took hsistency food. At 12:15 p.m. cian (RD) went past the DR unit. At 12:16 p.m. the trained MA)-A was observed to walk ypress Unit nursing station as ite. At 12:17 p.m. the director ind human resource director It o pass the DR while R92		 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 with have been assessed to require supervision are not left unattended in the Dining Room. 	e 10

HM6Y11

If continuation sheet 6 of 49
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		00923	B. WING		07/2	2/2015
	PROVIDER OR SUPPLIER	WHITE BEAR LAK 1891 FLC	DRESS, CITY, DRENCE STF EAR LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE
2 565	entered the DR ar asked R92 whether more and if she ner replied, "No." TMA and was observed R92 was observed stayed with her at the drink. R92's nutritional C dated 2/26/15, indi potential for alterations, self-feeding of chewing/swallowin Parkinson's diseas received assistance R92's care plan da a chewing problem care plan directed difficulty chewing, state a chewing problem care plan directed difficulty chewing, state a spiration, and to p physical help as ner indicated R92 dem alteration in nutrition self-feeding difficult difficulty related to slowly eating and c encouragement to directed staff to pro- reminders and phy the resident was each R92's undated nut assignment sheet assist with eating . On 7/22/15, at 12:2	straw. At that time TMA-A nd sat next to R92. TMA-A er she wanted to eat some beded help to which R92 -A continued to sit next to R92 assisting her. At 12:23 p.m. I to be done eating but TMA-A the table and assisted R92 to are Area Assessment (CAA) cated R92 demonstrated tion in nutrition due to weight difficulty and g difficulty related to se. The CAA indicated R92 se and supervision at meals. ated 3/7/11, indicated R92 had n related to Parkinson's. The staff to observe R92 closely for signs of choking and/or provide setup help, cueing, and eeded. In addition the care plan nonstrated potential for on due to weight loss, lty and chewing/swallowing Parkinson's disease with very drinking behaviors, and refusing eat and drink. The care plan ovide setup help, frequent vsical assist for meals because asily distracted during meals.		QA team will review audits compliance of dining room QA/IDT will determine if fu or staff guidance are requi The Director of Nursing/De responsible for maintaining Date of completion: Sept 1	supervision. rther education red. esignee is g compliance	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00923	B. WING		07/	23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
CERENI	TY CARE CENTER - V	VHITE REAR I AK	ORENCE STRE EAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 7	2 565			
	supposed to be in t was eating. RN-C f problems with swal disease. At the time also acknowledged left unsupervised w On 7/23/15, at 12:4 acknowledged R92 been followed and be in the dining roo	4 p.m. the DON 's plan of care should have stated, "staff are supposed to m until all residents are out. A upposed to be in the dining				
	SUGGESTED MET	HOD OF CORRECTION:				
	policies and procec plan was followed. inservice all staff to	sing could review and revise lures to ensure resident care The director of nursing could follow the resident care plan. sing could monitor staff				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			9/1/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00923	B. WING		07/23	8/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ERENI	TY CARE CENTER - V		RENCE STI EAR LAKE,			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLE DATE
2 830	Continued From pa	age 8	2 830			
	resident must rema prefers to remain ir	ain in bed or the resident ו bed.				
	by: Based on observat review, the facility f non-pressure relate	ent is not met as evidenced ion, interview and document failed to adequately monitor ed skin conditions for 1 of 2 ith observed bruising.		R239 Had an event report complet the identified bruises. R239's family and physician were aupdated and notified about the brobserved on the right and left thur	ruises	
	a large bruise on th small bruises on th interviewed and wa gotten the bruises. bruises, R239 was	d on 7/20/15, at 4:11 p.m. with he left thumb area and two e right arm area. R239 was as not able to indicate how he'd When asked about the observed to rub the bruised mb which R239 stated did not		R239's bruises on the thumb and arm have healed. The care plan was updated to refle current resident's needs and interv Residents who have been identifit have bruising have had the bruise	ect the ventions. ed to	
	his room seated on observed to have the the left thumb. On 7/22/15, at 7:41 R239's left thumb a	10 a.m. R239 was observed in a the recliner. R239 was still he large dark purple bruise on a.m. the large dark bruise on area was still present. In bruises on his right arm were k purple.		assessed and " daily observation of bruise till resolved" added to the e The facility policy /procedure titles Audit" was reviewed/revised on 8/ Staff has been reeducated on the ezpectations for reporting bruising skin impairments upon observatio routine monitoring of the bruise till resolved.	Tar. "Body 20/15. and n and	
	was still observed t Review of R239's F through 7/22/15, la	34 p.m. the left thumb bruise to be present. Progress Notes dated 7/1/15, cked documentation of any bruises. After the surveyor		Residents are observed for area of bruising with AM and HS cares. W skin observations are completed b nurse and findings are documente progress notes.	Veekly by a	

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
	00923	B. WING		07/	23/2015
ME OF PROVIDER OR SUPPLIER	VHITE BEAR LAK 1891 FLO	DRESS, CITY, PRENCE STF EAR LAKE,			
REFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
 staff, a nursing Proindicated R239 had and two bruises on indicated the meas the bruises were as - Bruise on left thur 2.0 cm dark purple - Bruises on right for bruise closer proximand distal to elbow R239's care plan daws at risk for skin decreased mobility. directed staff to cominspection with daily indicated staff were the bony prominent skin breakdown (so areas). During interview with unit manager of the on 7/23/15 at 10:55 impulsive and had at TCU which had cau RN-A stated R239 (blood thinner medireview of the prograssessments, that monitoring of R238 staff were expected noted, RN-A stated R239 (blood thinner medireview of the prograssessments, that monitoring of R238 staff were expected noted, RN-A stated R239 (blood thinner medireview of the prograssessments, that monitoring of R238 staff were expected noted, RN-A stated R239 (blood thinner medireview of the prograssessments, that monitoring of R238 staff were expected noted, RN-A stated R239 (blood thinner medireview of the nurse and that also be documente completed weekly. 	ncern to the attention of the gress Note dated 7/23/15, I one bruise on the left thumb the right arm. The note urements and description of a follows: nb was 4.2 centimeter (cm) by in color. prearm same dark purple with nity to elbow 1.8 cm by 1.6 cm 1.0 cm by 1.5 cm. ated 7/3/15, indicated R239 breakdown related to . Care plan interventions nduct a systematic skin y cares and weekly bath and to pay particular attention to ces and report any signs of ore, tender, red, or broken th the registered nurse (RN)-A e Transitional Care Unit (TCU) a.m., RN-A stated R239 was fallen during his stay in the used bruising. In addition, had a history of Coumadin ication) use. RN-A verified with ess notes and weekly skin risk there had not been routine D's bruises. When asked what d to do when bruising was d staff were supposed to report at resident bruising should d on the body audit forms	2 830	Audits of the weekly skin documentation, along wit observation of the resider completed 3 x weekly for weekly x 4 weeks and the monthto monitor for comp reporting and monitoring. The Director of Nursing/D responsible for maintainin Date of completion: Sept.	h a visual nt will be 4 weeks, then en monthly x1 bliance for Designee is ng compliance.	
	ruising, she would assess the				

Minneso	ta Department of He	ealth			I ONIV	APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		00923	B. WING		07/	23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CERENII	TY CARE CENTER - W		ORENCE STRE			
		WHILE	BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	morning, and she t	o stated R239 had fallen that hought the nurse conducting sment should have identified ported.				
	(DON) stated she e skin changes to the that when the week the nurse was supp Although a body au	(23/15, the director of nursing expected staff to report any e nurse. The DON also stated kly body audit was conducted, posed to identify any changes. udit had been conducted on g had been identified.				
	indicated the purpo all residents for ide integrity." The polic as needed to Intero Physician/NP (nurs	Audit policy dated 4/16/15, ose was "To be completed for entification of alterations in skin by included: "7. Communication disciplinary Team, se practitioner) and Family nges in skin integrity"				
	review, the facility f supervision with a who was at risk for	ion, interview, and document ailed to provide the necessary meal for 1 of 3 residents (R92) aspiration reviewed for random observation.				
	Findings include:					
	cerebrovascular dis speech language ti	cluded dysphagia, pneumonia sease, cough symptom, herapy, paralysis agitans and from Resident Admission d 7/23/15.	,			
	seated in the dining drinking herself and time nor around or -At 12:11 p.m. R92	0 p.m. R92 was observed g room (DR) eating and d no staff was in the DR at the close by. took a bite of pureed				
nesota D ATE FORI	epartment of Health		6899 LI	M6Y11	10 - 11 - 11	on sheet 11 o

AME OF PROVIDER OR SUPPLIER	00923				
AME OF PROVIDER OR SUPPLIER		B. WING		07/2	23/2015
	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
ERENITY CARE CENTER - W	/HITE REAR I AK	DRENCE STRE			
(X4) ID SUMMARY STA		EAR LAKE, MI	PROVIDER'S PLAN OF CO	BRECTION	(X5)
PREFIX (EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE
2 830 Continued From pa	ge 11	2 830			
 past the DR toward: -At 12:16 p.m. the tr (TMA)-A was obserr Cypress Unit nursin R92 took a bite. -At 12:17 p.m. the of human resource dir past the DR and at cart. At this same tri straw. -At 12:17 p.m. TMA next to R92 and asl some more and if s stated "No." TMA-A and was observed a -At 12:23 p.m. over she was done eatin table and was obser On 7/22/15, at 12:24 (RN)-C stated R92 with meals. RN-C a supposed to be in th RN-C further stated swallowing and had time of the conversa also acknowledged left unsupervised with On 7/23/15, at 12:44 with aspiration risk s dining room until all person was suppos dietary staff." 	egistered dietician (RD) went s Cedar unit. rained medication aide ved go by went towards the ng station at the same time director of nursing (DON) and rector were both observed go the time DON was pushing a me R92 took a sip using a A-A came into the DR and sat ked her if she wanted to eat he needed help and R92 a continued to sit next to R92 g and continued to stay at the rved assist R92 to drink. 8 p.m. registered nurse was supposed to be assisted icknowledged staff was he DR with R92 at the time. I R92 had problems with I Parkinson's disease. At the ation nursing assistant (NA)-A R92 was not supposed to be				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING		07/	23/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
ERENIT	Y CARE CENTER - V		DRENCE STRE EAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 12	2 830			
	Parkinson's disease assistance and sup R92's care plan dat a chewing problem care plan directed s difficulty chewing, s aspiration and to pr physical help as ne dated 3/10/11, indic potential for alterati loss, self feeding di	g difficulty related to e. CAA indicated R92 received vervision at meals. ted 3/7/11, indicated R92 had related to Parkinsons. The staff to observe R92 closely for igns of choking and/or rovide setup help, cueing, and eded. In addition care plan cated R92 demonstrated on in nutrition due to weight				
	Parkinson's disease drink behaviors and eat and drink. Care setup help, frequen assist for meals be distracted during m	e with very slowly eating and refusing encouragement to plan directed staff to provide t reminders and physical cause the resident is easily				
	staff to provide "Tot Assistance with Me 2013, directed: "1. Dining Room Re a. All residents the dining room. b. Facility Staff will help residents we eating. c. Residents we	al assist with eating"				
		HOD OF CORRECTION: sing or designee, could review				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ATE SURVEY OMPLETED
		00923	B. WING		07/23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
ERENI	TY CARE CENTER - V		ORENCE STI BEAR LAKE,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE ⁻ DATE
2 830	Continued From pa	age 13	2 830		
	provide staff educa residents. The dired	itoring and care, and could tion related to the care of ctor of nursing or designee udit tool to ensure appropriate			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015		8/20/15
	procedures and co	conditions. Sanitary nditions must be maintained ir dietary department at all	1		
	by: Based on observati review the facility fa conditions for ice m for cooking and/or y kitchenettes and ar main kitchen to pre borne illness. This of 135 residents wh	ent is not met as evidenced ion, interview and record ailed to maintain sanitary nachines in 3 of 7 kitchenettes griddle top pans in 6 of 7 n undated food item in the event the possibility for food had the potential to affect 133 no were served food and/or tchenettes and the main		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	
	kitchen. Findings include: During the kitchen	and facility tour on 7/20/15, at		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.	k
		ulinary Services Directors		 2.)Maintenance technician was brought out to fix leaking ice machines. A 	

	/IDER/SUPPLIER/CLIA TFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
009	23	B. WING		07/2	3/2015
AME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
ERENITY CARE CENTER - WHITE BE	ΔΒΙΔΚ	DRENCE STI EAR LAKE,			
X4) ID SUMMARY STATEMENT OF REFIX (EACH DEFICIENCY MUST BE F TAG REGULATORY OR LSC IDENTIF	DEFICIENCIES PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21015 Continued From page 14		21015			
Cedar Terrace kitchenette, the machine was noted to be dri heavy lime buildup on the ba pan. CSD-C verified it was d cleaned." The griddle top pa inches long by 8 inches wide all kitchenettes had a heavy substance on the cooking su Rosewood kitchenette, the g heavy buildup of a black sub cooking surface of the griddl Gardenview kitchenette, the was noted to be dripping, ha on the backsplash and drip p on the inside of the ice shoo and corners of the drip pan a the water that was collecting CSD-C stated he was not su been put in. Evergreen Trail kitchenette, was noted to have a heavy b substance on the cooking su Transitional Care Unit (TCU) the resident ice machine was dripping, had a heavy lime b backsplash and drip pan as brown matter on the inside o on the sides and corners of the griddle top pan had a heavy substance on the cooking su CSD-D stated an outside con responsible for cleaning the During a followup kitchen an 7/22/15, at 10:00 a.m. the fo	pping and had a cksplash and drip irty and "should be in approximately 16 which was found in buildup of a black irface of the griddle. riddle top pan had a stance on the e. resident ice machine d heavy lime buildup ban with brown matter t, around the sides and also floating in in the drip pan. re if a work order hac the griddle top pan uildup of a black irface of the griddle. on the second floor, s noted to be uildup on the well as a buildup of f the ice shoot and he drip pan. The buildup of a black irface of the griddle. mpany was ice machines. d kitchenette tour on		schedule for deliming ice regularly set up. 3.)Dietary managers held employees to explain info provide staff education on issues. Training included employees signed. Issue A.) Food in coolers withou proper labeling. B.) Procedures for cleanin C.) Procedures for cleanin 4.) Audits will be complete manager or assigned staff regulations are being met 5.) Additional staff educat corrective action will be pr compliance with regulation	training with rmation and infection control a packet s included: ut dates and ng ice machines. ng griddles. ed by dietary f to ensure ion and rovided to ensure	
and verified by the Dietary D					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING		07/	23/2015
	PROVIDER OR SUPPLIER	WHITE BEAR LAK 1891 FLC	DRESS, CITY, ST DRENCE STRE EAR LAKE, M	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21015	thawed frozen rasp cardboard box was approximately a qu surrounding it. The 7/6/15 shipping dat they were unsure of raspberries had be Cedar Terrace kitch machine was still d a 12 inch cast iron buildup of a black s surfaces. DD state pans was carbon b When DD scraped she was able to ren food particle buildu Rosewood kitchen same size as noted a black substance griddle. Gardenview kitche was still dripping. Evergreen Trail kito and a 12 inch cast	a ten pound bag (half full) of oberries stored in the original s sitting in a pan with larter inch of red juice box was not dated and had a te on it. DD and CSD-D stated of how long the thawed en in the refrigerator. henette, the resident ice hripping, a griddle top pan and cooking pan had a heavy substance on both cooking d the black substance on the wildup and could not come off. the heavy black substance move it and agreed that it was		DEFICIENC		
	machine was still d and a 12 inch cast	n the second floor, resident ice Iripping, the griddle top pan iron cooking pan had heavy substance on the cooking ns.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00923	B. WING		07/	23/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ERENI	TY CARE CENTER - V		RENCE STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	age 16	21015			
		, the griddle top pan had a black substance on the the griddle.				
	iron cooking pan h	n the first floor, the 12 inch cast ad heavy buildup of a black cooking surface of the pan.				
	food policy dated 3 potential for foodbo will be educated or and storage. It furth items must be in cl	age of Food, use of leftover //11, indicated that due to the prne illness the culinary staff in safe food handling practices her noted "all perishable food losed containers, labeled with is and the date it was				
	cleaning lists for th "wipe down the out drawers, stove top	ity Days and Nights daily e kitchenettes indicated to tside of the cupboards, , ice machine/juice machine" and pan, put oil on griddle."				
	indicated the Culina maintained in a cle that cleaning sche listed, will be provid cleaning tasks com appropriate manne responsible to know	ed Cleaning Schedules policy, ary Department will be an and sanitary condition and dules, with all cleaning tasks ded in the department and npleted in a timely and er. Each culinary personnel are w their assigned cleaning d to carry them out during their				
	DD stated that ECC ice machines in the should be cleaning been that bad. We	on 7/21/15, at 2:00 p.m. the OLAB was responsible to clean e kitchenettes, but dietary staff them daily, "it shouldn't have have had problems with the e got them, they need to be				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED
		00923	B. WING		07/23/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
ERENI	TY CARE CENTER - V		ORENCE STF BEAR LAKE, I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
21015	Continued From pa	ige 17	21015		
	replaced."				
	DD stated she does back all of the time	on 7/23/15, at 11:11 a.m. the sn't get the cleaning sheets , "I need a new system." DD e ECOLAB was out to delime ras on 2/24/15.			
	The administrator a	THOD OF CORRECTION: and dietary manager could to dietary sanitation and ince.			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One)		
21325	MN Rule 4658.072 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325		9/1/15
	home must provide resource, routine d needs of each resid include dental exar fillings and crowns, oral surgery, bridge orthodontic proced that are provided for	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the , as limited by third party icies.			
	by:	ent is not met as evidenced ion, interview, and document		R28 Had an oral Assessment complete	d
	review, the facility f	ailed to provide routine dental residents (R28) reviewed for		on 7/23/2015	-
		dentures did not fit properly.		R28 was offered Dental Services and h an appointment scheduled for 8/26/201	
	Findings include:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00923	B. WING		07/23/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ERENI	Y CARE CENTER - W	VHITE REAR LAK	RENCE STI EAR LAKE,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLET
21325	Continued From pa	ge 18	21325		
	have no teeth or de time, R28 stated sh them out during her dentures, R28 state after her admission she was eating just	on 7/21/15 at 10:49 a.m. to entures in her mouth. At that he had dentures but had taken r nap. When asked about her ed she'd lost weight before and to the facility and although fine now, the dentures were th was occassionally sore as a		All other residents have had documentation reviewed to verify the have had an Oral Assessment correction within the past 12 months and if con- were identified on the Oral Assess dental services were offered or fol- was verified and documented. R28 has had her care plan update reflect current status with her dent	npleted oncerns ment, low-up d to ures
	resident's weight lo dated 7/20/15, indic 134.6#. A nutritiona indicated the reside on 1/22/15. The re	tional notes verified the ss. A quarterly nutrition note cated R28's weight was al note dated 1/23/15, ent's weight had been 173.6# sident's record identified contributing to the weight loss.		and reviewed at care conferences Clinical Comprehensive Admission Assessment will be conducted on admissions with in 24 hours. Audit be conducted by clinical managers The faciliy policy/procedure related "Dental Care" was reviewed/revise	n all ing will s daily. d to
	1/27/15 indicated th dentures/appliance	t conducted on R28 on ne resident had "ill-fitting ." The assessment summary oes not c/o (complain of)		The Staff have been re-educated expectations related to dental care residents.	
	mouth problems. S stay moist as long a	She says her lips and mouth as she has water on her table. r upper dentures bother her a		Audits will be completed on all res during their ARD a Comprehensive Assessment x3 months to ensure residents have an Oral Assessment completed per facility policy and	e nt
	required assist of o	ed 4/20/15, indicated R28 ne for oral care and that R28 er dentures, but had no rinking.		completeed per facility policy and follow - up action required is comp and documented, including offerin services.	leted g dental
	stated she was una R28, and RN-F stat	on 7/22/15, at 2:29 p.m. RN-F ware of any dental issues for ted she was not sure whether		Audit results will be reviewed by the committee and decisions made at further audit needs.	pout
		ntist since her admission on ed, "I will call her daughter to		The Director of Nursing/designee responsible for maintaining compli- Date of Completion: Sept. 1, 2015	ance.

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING		07/	23/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ERENI	TY CARE CENTER - V	νμιτε βεδριδκ	ORENCE STRE BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21325	Continued From pa	ige 19	21325			
	licensed practical n	on 7/23/15, at 12:19 p.m. urse (LPN)-F stated she was ntal issues for R28.				
	MDS coordinator (assessment would computer system) I if not she would no a dental appointme MDS-B stated "son	on 7/23/15, at 12:53 p.m. MDS)-B stated normally an orabe in Matrix (electronic before completing an MDS and tify nursing to complete it, and ont would take place if needed. nething should have been 7/15) oral assessment nurse."	k			
	at 1:47 p.m., MDS-	rview with MDS-B on 7/23/15 B verified there had been no at to adjust the ill-fitting				
	The director of nurs and revise policies dental care for resided education related to procedures. The di	THOD OF CORRECTION: sing or designee, could review and procedures related to dents and could provide staff o these policies and rector of nursing or designee udit tool to ensure appropriate				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance	0 Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in				9/1/15

STATE FORM

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00923	B. WING		07/23/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY,	STATE, ZIP CODE	
ERENI	TY CARE CENTER - V		DRENCE STI EAR LAKE,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21390	Continued From pa	age 20	21390		
	control of outbreak C. isolation and reduce risk of trans D. in-service e prevention and com E. a resident h immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po practices, including defined in part 465 G. a system fo H. a system fo products which affe disinfectants, antise incontinence produ	ealth program including an ram, a tuberculosis program as 58.0810, and policies and dent care practices to assist in treatment of infections; ment and implementation of policies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and			
	by: Based on observat review, the facility f infection control me cares for 2 of 3 res incontinence. In ac ensure that clean li and sanitary manne	ent is not met as evidenced ion, interview and document failed to ensure appropriate easures were used during idents (R92, R19) reviewed for ddition, the facility failed to nens were stored in a clean er; and failed to ensure jiene was performed during		NA - B and NA - E were immediately re-educated on the facilities policy regarding washing hands and changir gloves when providing care for reside NA - D was immediately re-educated the expectations of hand washing, including how to manage hand washin when wearing a splint.	on

HM6Y11

If continuation sheet 21 of 49

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
00923	B. WING		07/2	3/2015
STREET AI NHITE BEAR I AK 1891 FLC	DRENCE STR	REET MN 55110		(X5)
Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG			COMPLE
o be applied between R92's d after NA-B finished applying ess cream was wiped off the o cloth and the cloth was thrown night stand. NA-B informed going to put the incontinent pad R92's socks and pants. NA-B, es that were used to provide ther clean wet wash cloth to A-B told R92 that she was 92's gown and after removing on the floor. NA-B washed and nderarms and attempted to owever R92 refused the aring the same gloves, NA-B towards the wall and adjusted		ensure infection control prace followed during resident mea Clean linen storage areas wi on the same schedule to ensi- items are not stored in the cl areas. Audits will be reviewed by Q and determine if further educ action plans need impletation The Director of Nursing / De reponsible for maintaining co	tices are al service. ill be auditied sure personal lean linen A/IDT team cation or n. signee is ompliance.	
	IDENTIFICATION NUMBER: 00923 STREET AI WHITE BEAR LAK ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 21 ssist R92 with morning cares. set up at the bedside and, A-B proceded to perform A-B used several clean wet to clean R92's bottom, which 6 a.m., NA-B informed R92 that o be applied between R92's d after NA-B finished applying ess cream was wiped off the o cloth and the cloth was thrown night stand. NA-B informed going to put the incontinent pad R92's socks and pants. NA-B, es that were used to provide ther clean wet wash cloth to A-B told R92 that she was 92's gown and after removing on the floor. NA-B washed and nderarms and attempted to owever R92 refused the aring the same gloves, NA-B towards the wall and adjusted hen asked NA-A for assistance 8:48 a.m., NA-B picked the nd bagged it, opened the ne bedside stand to obtain a o empty the urine out of R92's posed of the urine in the toilet. inder, dried it with paper it in the bottom drawer of the oplies that had been used ck in the other two drawers of At 8:59 a.m., NA-B removed er washed her hands. At 9:00	IDENTIFICATION NUMBER: A. BUILDING 00923 B. WING	IDENTIFICATION NUMBER: A. BUILDING: 00923 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1991 FLORENCE STREET WHITE BEAR LAK MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 21 Ssist R92 with morning cares. set up at the bedside and, A-B proceded to perform A-B informed R92 that o be applied between R92's d after NA-B informed R92 that o be applied between R92's d after NA-B finished applying ess cream was wiped off the cloth and the cloth was thrown night stand. NA-B informed go?s gown and after removing nith effoor. NA-B washed and drearms and attempted to owever R92 refused the aring the same gloves, NA-B towards the wall and adjusted hen bedside stand to obtain a o may the urine out of R92's tosta may the urine in the toilet. inder, dried it with paper it in the bottom drawer of the p2's gown, and after removing no the foor. NA-B broked the not bagged it, opened the	IDENTIFICATION NUMBER: A. BUILDING: COMP 00923 B. WING 07/2 STREET ADDRESS, CITY, STATE, ZIP CODE 1891 FLORENCE STREET 07/2 WHITE BEAR LAK WHITE BEAR LAKE, MN 55110 TEMEMENT OF DEFICIENCIES ID ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE Sci DENTIFYING INFORMATION) TAG COMPletion Constructions and attempted to perform CROSS-REFERENCED TO THE APPROPRIATE A-B proceded to perform A-B proceded to perform Completed on the same schedule to ensure personal terms are not stored in the clean linen areas. Completed on the same schedule to ensure personal terms are not stored in the clean linen areas. A dafter NA-B finished applying ass cream was wiped off the clean wet wash cloth to A-B told R92 that she was go?s gown and after removing in the floor. NA-B washed and determine if further education or action plans need impletation. The Director of Nursing / Designee is reponsible for maintaining compliance. B2's gown and after removing in the floor. NA-B washed and determine and attempted to owever R92 refused the anaring the same gloves, NA-B towards the wall and adjusted hen asked NA-A for assistance Date of Completion Sept. 1, 2015 B2's gown and after removing in the floor. NA-B picked the neb bedside it, oppend the end bagged it, oppend the endend the other wo drawers of At 8:59 a.m., NA-B picked the neb bedside the neb tobedside

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING		07/	23/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1891 FI (ORENCE STRE			
EKENI	TY CARE CENTER - V	WHITE BEAR LAK WHITE E	BEAR LAKE, M	IN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE ⁻ DATE
21390	Continued From pa	age 22	21390			
	side of the bed and was attached to the using bare hands. I R92, informed R92 brush teeth and wit donned a pair of gle and told R92 she w get another cup. N/ without washing ha retrieve another cup came back to the ru gloves, brushed R9 bathroom to rinse t the gloves and ass When finished NA- breakfast" and whe After NA-B had stat asked R92 what sh walking towards the 9:10 a.m., NA-B wa acknowledged she after removing glov gloves after providi asked what the fac stated "I usually do am done and gettin asked if she was su after performing pe we have not been t On 7/22/15, at 9:19 was interviewed an supposed to chang providing pericare a resident.	had not washed her hands ves and had not changed ng R92 pericare. NA-B was ility policy was and NA-B not remove my gloves until I ng the linen, like I did." When upposed to change gloves pricare NA-B stated, "I guess				

STATEMENT C	Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING		07/	23/2015
NAME OF PRO	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
CERENITY	CARE CENTER - V		ORENCE STRE BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390 C	ontinued From pa	age 23	21390			
pe		wash hands, and with e gloves and wash hands				
frito w pi R a a a N in th b R cl g a fa cl R to to th ha p p b b th th w	om 7:57 a.m. to 8 o assist R19 with r ashing hands, NA icked up the fall n 19's bed, folded i ead of the bed. N ssisted her to get mbulated R19 to A-E took off R19' the trash can an the toilet. NA-E cou- ody with her night 19, filled a basin ean washcloths c ave one wet wash ace, then a dry tow ean incontinent p 19's legs while R bilet. With the sam buched the bottom hem off R19, went andles, got a ano ut on R19's legs, roduct, put both s ottom of the shoe hen took off her gl	s observation, on 7/22/15, 3:30 a.m., NA-E was observed morning cares. Without A-E put on a pair of gloves, hat that was on the side of t and put it away next to the A-E took off R19's tabs alarm, up on the side of the bed, and the toilet in the bathroom. s incontinent product, placed it d assisted R19 to sit down on vered R19's bottom half of gown, took the transfer belt of with warm water, placed two on the side of the wash basin, heloth to R19 who washed her vel to wipe her face, and put a roduct around the bottom of 19 was still sitting down on the he gloved hands, NA-E n of both shoes, while taking t to the closet, touched closet ther pair of jeans which were just below the incontinent hoes back on, touching the s, and tied the laces. NA-E oves, took off the night gown R19, put new gloves on, we bede	f			

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00923	B. WING		07/	23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CERENI	TY CARE CENTER - W	ΛΗΙΤΕ REAR Ι ΔΚ	RENCE STRE EAR LAKE, M			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21390	Continued From pa	ge 24	21390			
	from the top drawer brushed R19's top of placed them on the clean paper towel, g paste on the brush brushed her bottom spit in a container N right hand was resti she waited for R19 toothbrush and put gave R19 her top d NA-E put paper tow the transfer belt on towels in a plastic b of the resident and put them on. NA-E hands, put new glow wet washcloth and front to back, folded from front to back. I pad up, then R19's wash hands and as her wheelchair situa NA-E hooked up the wheelchair, brough NA-E then went to t the nursing station a few minutes, NA- adjoining dining roo door and opened it. time, 8:30 a.m., and washed her hands a will usually wash ha out, "I know I forgot	brush, toothpaste and dentures r, situated next to the sink, dentures with toothpaste, right side of the sink on a got another toothbrush, put and gave it to R19 who in teeth, swished with water and VA-E was holding. NA-E's ing on the edge of the sink as to finish. NA-E rinsed R19's in a container. NA-E then enture who put it in her mouth. <i>rels</i> in the trash bag, placed the resident, placed the bag, placed the walker in front handed glasses to R19, who took off gloves, did not wash ves on, obtained a different washed R19's peri-area from d the washcloth, again washed NA-E pulled the incontinent pants, took off gloves, did not isisted R19 using her walker to ated outside the room door. e tabs alarm on the t R19 out to the dayroom. the pastry container situated at used tongs to put a muffin on hen went to the closet next to to talk with another aide. After E turned and went to the om, touched the refrigerator NA-E was interviewed at this d stated she should have after washing R19's face and ands after taking the dirty linen the table and went by the dirty linen the table and between				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING		07/	23/2015
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE		
		1891 EL	ORENCE STRE			
ERENI	TY CARE CENTER - V	WHITE BEAR LAK WHITE E	BEAR LAKE, M	N 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21390	Continued From pa	age 25	21390			
	RN-F stated hands glove changes, bef leaving a resident's touched, before yo between top and be During an interview RN-C explained tha hands and changin	v on 7/23/15, at 9:59 a.m., at staff should be washing ng gloves, always between r pericares,"I always say if in				
	Unit (TCU), on 7/20 linen door was ope linen cart was visib cover over the liner personal blue gree and lighter in the po a banana on top of At 12:43 p.m. RN- usually kept shut a staff personal items	B explained that the door was nd that it was unusual to have s there, referring to the lighter -B closed the door, however,				
	dining room on 7/2 wash hands upon e before delivering pl noted to have a rig to be made of hard a Velcro strap arou At 5:34 p.m., NA-D resident's wheel ch passed coffee to an	n observation in the Cedar 0/15 at 4:43 p.m., NA-D did no entering the dining room or lates to residents. NA-D was ht hand splint which appeared I plastic around two fingers and and the right hand. Was observed to push a hair up to the table and then nother resident. NA-D then upper plate and used three				

00923 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 07/23/2015 CERENITY CARE CENTER - WHITE BEAR LAKK 1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110 WING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
WHE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1891 FLORENCE STREET WHITE BEAR LAK 1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION NEOCIDIN (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION NEOCIDIN (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION NEOCIDIN (EACH CORRECTIVE ACTION ACTION NEOCIDIN (EACH CORRECTIVE ACTION STREET DEFICIENCY) (xs) (completion 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. 21390 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 statff 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 On 7/23/15, at 2:47 p.m., the director of nursing			00923	B. WING		07/	23/2015
1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110 (X4) ID (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEATTORY OR LSC IDENTIFYING INFORMATION) 21390 Continued From page 26 21390 21390 Image: Solar So						07/1	23/2013
CARE CENTER - WHITE BEAR LAKE WHITE BEAR LAKE, MN 55110 Image: Construct of the state of the s	NAIVIE OF F	ROVIDER OR SUPPLIER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) completer DATE 21390 Continued From page 26 21390 21390 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. 21390 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 on number has a splint were supposed to do hand hygiene, change gloves between residents, after	CERENII	Y CARE CENTER - W					
21390Continued From page 262139021391fingers 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.Image: Continued From page 26At 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."Image: Continued From page 26On 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.Image: Continued From page 26On 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, afterImage: Continued From page 26	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLET
 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 	21390	Continued From pa	age 26	21390		,	
		prepare the ribs for observed to wash t At 5:43 p.m. NA-D dining room and up before passing food At 6:10 p.m., NA-D hands and did rem 6:34 p.m., NA-S sta splint." On 7/22/15, at 2:05 member has a splin them to remove it in otherwise to wear a during any cares. On 7/23/15, at 12:4 (DON) stated staff	r R41 to eat. NA-D was the fingers of her right hand. wheeled a resident out of the bon return did not wash hands d plates to residents. 9 was observed washing her ove splint. During interview, at ated, "I am able to remove the 5 p.m., DON stated "If a staff nt on their hand I would expect f able and wash as normal, a glove to cover the splint 47 p.m., the director of nursing were supposed to do hand				
		b. When hands washing with soap c. Before and after which hand hygiend professional praction d. Before and a	ng on duty; s are visibly soiled (hand and water); direct resident contact (for e is indicated by acceptable ce); after performing any invasive				
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	mesota D	sampling); e. Before and a epartment of Health	after entering isolation				

STATE FORM

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00923	B. WING		07/	23/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CERENIT	Y CARE CENTER - V	νμιτε βεδριδκ	ORENCE STRE BEAR LAKE, M			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE
21390	Continued From pa	ige 27	21390			
	 washing with soap g. Before and a meals; h. Before and ad personal care (e.g. i. Before and ad vascular catheter a j. Before and ad vascular catheter a j. Before and ad catheters; k. Before and ad catheters; k. Before and ad or blood pressure, a m. After persor washing with soap n. Before and ad toileting (hand wash water); o. After contact with diarrhea including, caused by noroviru difficile (hand wash p. After blowing q. After contact membranes and box r. After handling dressings, bedpans s. After handling there perform (hand washing with u. After removing v. After comple 7. Hand hygiene is removing and disponent.	fter or handling food (hand and water); after assisting a resident with oral care, bathing); fter handling peripheral nd other invasive devices; fter inserting indwelling after changing a dressing; oming in contact with a n, (e.g., when taking a pulse and lifting a resident); nal use of the toilet (hand and water); after assisting a resident with hing with soap and n a resident with infectious but not limited to infections s, salmonella, shigella and C. ing with soap and water); g or wiping nose; with a resident's mucous bdy fluids or excretions; g soiled or used linens, s, catheters and urinals; g soiled equipment or utensils ing your personal hygiene soap and water); ng gloves or aprons; and ting duty always the final step after psing of personal protective				
	8. The use of glove handwashing/hand					
nesota De	epartment of Health		6899 LI			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING		07/	23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CERENI	TY CARE CENTER - V		ORENCE STRE BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 28	21390			
	2013, directed: "7. All employees v assistance with me demonstrate comp	eals policy revised September who provide resident eals will be trained and shall etency in the prevention of ncluding personal hygiene food handling."				
	The director of nurs that infection contro up to date and that and evaluated to as	THOD OF CORRECTION: sing or designee could assure of policies and procedures are staff are trained, monitored ssure good hand washing and of sufficiently when caring for				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21545	MN Rule 4658.132	0 A.B.C Medication Errors	21545			9/1/15
	percent as describe Guidelines for Cod 42, section 483.25 the State Operation Surveyors for Long incorporated by ref purposes of this pa (1) a discrepa prescribed and wha administered to res (2) the admini medications.	ust ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of ns Manual, Guidance to I-Term Care Facilities, which is erence in part 4658.1315. For art, a medication error means: ncy between what was at medications are actually sidents in the nursing home; or stration of expired any significant medication				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00923	B. WING		07/23/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
CERENIT	Y CARE CENTER - V	νμιτε βεδριδκ	ORENCE STR BEAR LAKE, M		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
21545	Continued From pa	age 29	21545		
	(1) an error of discomfort or jeopa safety; or (2) medication requires the medication be titrated to a spec- medication error co- precipitate a reoccu- toxicity. All medication prescribed. An inco- error report must be that occurs. Any si resident reactions r physician or the phi- resident or the resid- designated represe- must be made in the C. All medication prescribed. An inco- report must be filed occurs. Any signifi- resident or the resid- designated represe- must be filed occurs. Any signifi- resident or the resid- designated represe- must be made in the phi- resident reactions r physician or the phi- resident or the resid- designated represe-	medication error is: which causes the resident ardizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single build alter that level and urrence of symptoms or cions are administered as cident report or medication e filed for any medication errors gnificant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. ons are administered as ident report or medication error d for any medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record.	/		
	by: Based on observat review, the facility f free of significant ir 1 of 4 residents (R	ent is not met as evidenced ion, interviews and document ailed to ensure residents were isulin administration errors for 55).		1 to 1 education provided to Rn-B regarding use of Flex Pen on 7/23/15 A medication error report was comple per facility policy on 7/23/15	
	Findings include:	inimum Data Set (MDS) dated		R55 insulin orders were reviewed wit physician on 7/23/15	h the

STATE FORM

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If continuation sheet 30 of 49

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPL	
		00923	B. WING		07/23/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
	Y CARE CENTER - V		ORENCE STR EAR LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLE DATE
21545	Continued From pa	ige 30	21545			
	 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 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. 			Residents with insulin orders, with insulin administered with a flex had their orders and blood gluc monitoring results reviewed with physicians. Nurses were re-educated on madministration including how to dispense and administer insuling flex pen on 5/21/15, 5/27/15, 7/7/24/15.	pen, have ouse h the edication accurately n using a	
				The facility has added education demonstration on how to use a part of new orientation for newl nursing staff. Audits will be completed daily x then 3x weekly for 2 weeks, the for 4 weeks and monthly for q r double check accuragy with ins administration when a flex pen Review of all Nursing personel was conducted to ensure all Nu- were re-educated on Flex pen administration. Orientation competencies will b during new employee orientation	flex pen as y hired 2 weeks, en weekly month to sulin is used. training ursing staff pe obtained on.	
	medical doctor (ME dosage due to rece the 400 range when range." MD-F state	on 7/23/15, at 9:36 a.m.)-F stated, "I Increased insulin ont increase in blood sugars to n patient is normally in the 250 d that not priming the insulin ursing issue, but would not		The Director of Nursing/design responsible for maintaining cor Date of Completion: Sept. 1, 20	npliance.	

Minneso	ta Department of He	ealth			FUNIM	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING		07/23/2015	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			20/2010
		1891 FI (DRENCE STRE			
CERENI	Y CARE CENTER - V	ΝΗΙΤΕ ΒΕΔΒΙΔΚ	EAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21545	Continued From pa	age 31	21545			
	cause a significant	cause a significant change in R55 blood sugars.				
	director of nursing a using insulin pens i prepare an insulin p wipe the tip of the i wipe, attach a need push the top of the and then dial the do receive. She stated insulin pen you will	on 7/23/15, at 1:05 p.m. the stated they had just started in June of 2015. She stated to pen for injection a nurse would nsulin pen off with an alcohol dle, dial up two units of insulin, pen to prime the insulin pen ose that the resident is to d that if you do not prime an not give the correct dose of staff was trained on using				
	Dispensing Solution directed the provide safety test to ensur the insulin to preve The instructions we Perform a Safety te Always perform the injection. Performin you get an accurate ensuring that p removing air bu A. Select a dose of selector. B. Take off the oute remove the used not the inner needle ca C. Hold the pen wit D. Tap the insulin re bubbles rise up tow	 Safety test before each ing the safety test ensures that is dose by: ben and needle work properly ubbles 2 units by turning the dosage er needle cap and keep it to eedle after injection. Take off up and discard it. th the needle pointing upwards eservoir so that any air wards the needle. on button all the way in. Check 				
		erform the safety test several				
nnesota D ATE FORI	epartment of Health		6899	M6Y11		on sheet 32 o

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00923	B. WING	B. WING		23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1891 FI (ORENCE STR			
CERENI	TY CARE CENTER - V	WHITE BEAR LAK WHITE B	BEAR LAKE, M	IN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	ige 32	21545			
	 If no insulin cor and repeat the safe remove them. If still no insuli be blocked. Chang If no insulin con needle, your SoloS use this SoloStar." The package insert Dispensing Solution directed the provide to ensure the accur to prevent under-doinstructions were a KwikPen - Importar Prime every tim a stream of insulin sure the Pen is rea If you do not pritoo little insulin. Frequently Asked Control with the provide to confirms that a of the tip of the need Knob in. Removes air the insulin cartridge du What should I of in the Dose Knob with the pose Not should I of in the Dose Knob with the pose Remember, do not 	mes out, check for air bubbles bety test two more times to in comes out, the needle may e the needle and try again. omes out after changing the tar may be damaged. Do not it for Lantus SoloStar insulin by ns, Inc. revised on 9/27/12, er/consumer to prime the pen racy of dispensing the insulin osing or overdosing. The s followed: "Priming Humalog nt Notes ne. The Pen must be primed to before each injection to make dy to dose. ime, you may get too much or Questions about Priming rime my KwikPen before each at the Pen is ready to dose. a stream of insulin comes out edle when you push the Dose nat may collect in the needle or ring normal use. do if I cannot completely push when priming the KwikPen? w needle.				
nnesota D	in the insulin cartric	lge. A small air bubbles to collect lge. A small air bubble will not d you can continue to take				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED	
		00923	B. WING	07	07/23/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S			
ERENI	Y CARE CENTER - V	νμιτε βεδριδκ	.ORENCE STR BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
21545	Continued From pa	ige 33	21545			
	your dose as usual					
	provided by Merwir and 5/27/15. Topics Flex Pen" Instruction Pen Turn the dose Press and hold the drop appears." Rev dated 5/21/15 and	d inservicing information h Pharmacy between 5/21/15 is included "How to use your ons included "Prepare your selector to select 2 units. dose button. Make sure a view of attendance sheets 5/27/15, provided did not inded inservice training on how	1			
	facility could review administration, prov administration, and	THOD OF CORRECTION: Th their policies on medication vide education on medication implement an auditing syster lication administration and e.				
	TIME PERIOD FOI days.	R CORRECTION: Seven (7)				
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610		9/1/15	
	must store all drugs under proper tempe	e of drugs. A nursing home s in locked compartments erature controls, and permit sing personnel to have				
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview and record ailed to securely store f 5 nursing units reviewed for		LPN - C was immediately re-educated on the expectations to secure medications in the cart and lock the cart when unattended.		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00923	B. WING		07/2	3/2015
AME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
ERENI	TY CARE CENTER - V		DRENCE STI EAR LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21610	Continued From pa	age 34	21610			
	Findings include: On 7/22/15, during the medication cart observed to be unlek key lock was obser unlocked position. from the nursing st pain) for R325 was cart. When intervie licensed practical r she had left the car During a random o a.m. the Cedar me observed to be unlek (RN)-C was notified of the medication r RN-C. In addition the contained a sealed only with a number kit contained 2 vials vials of insulin. RN- room door should a could take it (emery was working the ur key, but had not ch it was unlocked. Review of facility ped dated 2001 (revised "The facility shall in a safe, secure, a shall not use discond deteriorated drugs Compartments (drawers, cabinets,	an observation at 8:52 a.m. t on the Cedar unit was ocked and unattended. The rved to be fully extended in the The cart was located across ation. Voltaren gel (a cream for left unattended on top of the wed on 7/22/15 at 8:56 a.m. hurse (LPN)-C acknowledged rt open and unattended. bservation on 7/23/15, at 8:02 dication room door was ocked. Registered nurse d of the unlocked door. A tour oom was conducted with to the unlocked door, there medication refrigerator which plastic emergency kit sealed ed plastic tab. The emergency s of Lorazepam 2mg /ml and 2 -C stated, "the medication always be locked. Someone gency kit) right out." RN-F who hit stated she had just used the pecked the door to see whether olicy for Storage of Medication d 2007) included: store all drugs and biological's ind orderly manner facility ntinued, outdated, or including, but not limited to rooms, refrigerators, carts, ning drugs and biological's		A lock was added to the refrig Cedar medication room to see medications that require refrid double-locks. All medication have had capacity to unlock of button pad have been remove now only open using a key. All Medication carts and Med were checked for expired me and medications that were no opened, as required, were removed/destroyed on 8/20/2 Nurses received re-education policies related to checking la medication, removal of expire medications, and keeping me secure in a locked medication locked medication room on 9 Audits will becompleted week months, then monthly for 1 m medication carts / medication properly for administration. Audits will be completed 3x w weeks, then weekly for 4 week monthly for 1 month to obser medication carts and medicat as well as observing for no m left unattended / unsecured. Audit results will be reviewed committee and decisions ma further audits need.	coure geration and room doors using a push ed. Doors ication rooms edications, of dated when of dated when of dated when 2015. In on facilities abels on ed edication in cart, or /1/2015. kly x 2 nonth on all n rooms to are removed / s are labeled weekly for 4 eks, and ve for locked tion rooms, nedications by the QA	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00923	B. WING		07/2	3/2015
	PROVIDER OR SUPPLIER	WHITE BEAR LAK 1891 FLC	DRESS, CITY, DRENCE STI EAR LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLE DATE
21610	SUGGESTED MET administrator, direc consulting pharmac policies and proced medications. Nursi necessary to the in medications. The E the pharmacist, con basis to ensure con TIME PERIOD FOI (21) days. MN Rule 4658.134	THOD OF CORRECTION: The etor of nursing (DON) and cist could review and revise dures for proper storage of ng staff could be educated as nportance of properly securing DON or designee, along with uld conduct audits on a regular mpliance. R CORRECTION: Twenty one 5 Labeling of Drugs nursing home must be labeled		Director of Nursing / Designee w proper funcioning of locks, any malfunction if not working and w Maintanence Department for rep Date of Completion : Sept. 1, 20	vill report to pairs.	9/1/15
	by: Based on observat review, the facility f were appropriately outdated medicatio on 2 of 5 nursing u storage. Findings include: On 7/23/15, at 7:30 care unit (TCU) me for medication stor medication used to located in the top d but lacked a prescri	ent is not met as evidenced ion, interview and document failed to ensure medications labeled, and failed to ensure ons were not available for use nits reviewed for medication 0 a.m. the first floor transitional edication cart #2 was observed age. A Lantus Solostar pen (a o control blood sugar) was lrawer of the medication cart, ription label; It was unable to whom the Solostar pen had		LPN - C was immediately re-edu the expectations to secure med the cart and lock the cart when unattended. A lock was added to the refriger Cedar medication room to secu medications that require refriger double-locks. All medication roo have had capacity to unlock usi button pad have been removed now only open using a key. All Medication carts and Medica were checked for expired medic and medications that were not c	ator in the re ration and om doors ng a push Doors tion rooms cations,	

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If continuation sheet 36 of 49

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00923	B. WING		07/23/2015	
	PROVIDER OR SUPPLIER	NHITE BEAR LAK 1891 FL	DDRESS, CITY, ORENCE STI BEAR LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21620	been dispensed or There were 220 ou insulin dispense per formula plus Zinc (found in the cart wi The label indicated 1/3/14. A bottle of with vitamin d 400 dated as opened 7 expiration date was although no one wa medications, the er available for use. A was not dated whe was within last 28 of On 07/23/15, at 7:3 of the first floor TC Stored in the media undated open vial testing), dispensed the vial was opene bottle of Cranberry opened 8/22/14, th date was 6/15. RN taking the cranberr the nurses should expiration and rem On 7/23/15, at 7:50 the Cyprus Court n LPN-E. Stored in ta an expired vial of A the Aplisol was dat 4/15, and was expired A review of the ma indicated; "Vials in should be discarded	when it had been dispensed. It of 300 units remaining in the en. A bottle of advanced stress nutritional supplement) was ith an expiration date of 3/15. I the bottle had beens opened calcium 600 milligrams (mg) iu (international units) was /16/15. The manufacturer's s 5/15. RN-B verified that as currently using these xpired medications remained A Lantus Solostar pen for R55 n opened, the dispensed date		opened, as required, were nerved/destroyed on 8/20/2 Nurses received re-educatio policies related to checking I medication, removal of expir medications, and keeping medications, and keeping medication locked medication room on 9 Audits will becompleted wee months, then monthly for 1 n medication carts / medication ensure expired medications destroyed and all medications destroyed and all medications properly for administration. Audits will be completed 3x weeks, then weekly for 4 wer monthly for 1 month to obser medication carts and medicat as well as observing for no n left unattended / unsecured. Audit results will be reviewed committee and decisions ma further audits need. Director of Nursing / Designe proper funcioning of locks, a malfunction if not working an Maintanence Department for Date of Completion : Sept. 1	2015. n on facilities abels on ed edication n cart, or 2/1/2015. kly x 2 nonth on all n rooms to are removed / is are labeled weekly for 4 eks, and rve for locked ation rooms, nedications d by the QA ide about ee will lensure ny id will report to r repairs.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY
		00923	B. WING		07/2	23/2015
	PROVIDER OR SUPPLIER	1891 FI	DDRESS, CITY,	STATE, ZIP CODE		
CERENI	Y CARE CENTER - V	νηίτε βεδριδκ	BEAR LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21620	Continued From pa	ge 37	21620			
	administrator, direct consulting pharmatic policies and procect medications. Nursin necessary to the im medications proper medications. The D the pharmacist, cour regular basis to ens	THOD OF CORRECTION: The tor of nursing (DON) and cist could review and revise lures for proper storage of ng staff could be educated as portance of labeling ly and discarding expired DON or designee, along with uld audit medications on a sure compliance. R CORRECTION: Twenty one				
21805	Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights us treatment. Patients and	21805			9/1/15
	courtesy and respe	right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review, the facility f dining experience f	ent is not met as evidenced ion, interview and document ailed to provide a dignified or 1 of 5 residents (R190) on 1 of 8 residents R38 on		Staff have been re-educat policy/porcedure for assis mealtime which inclludes that staff will be seated ne who requires staff assista meal. 9/1/2015	ting resident's at the expectation est to a resident	
	meal on 7/20/15, at (NA)-F was observed	assistance with her evening 4:54 p.m. Nursing assistant ed standing as she fed R190 ere were chairs available for		Dining Room audits to mo seated while resident's ea be conducted by nursing p randomly including both m weekly for 4 weeks then 1	t their meal will personnel neal times, 3x	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00923	B. WING		07/2	3/2015
	(EACH DEFICIENC)	VHITE BEAR LAK 1891 FLO	DDRESS, CITY, DRENCE STI EAR LAKE, ID PREFIX TAG		ON SHOULD BE	(X5) COMPLE DATE
21805	staff to use and the sit in a chair. R38 was provided a continental breakfa NA-G was observe pureed doughnut a was one of two resi time. There were a while helping R38 t NA-H and NA-I wer 3:15 p.m. They bot assisting a resident The unit manager, interviewed on 7/23 explained sometim needed to move fro but sitting at eye lev and best for the resi The facility policy A September 2013, ir cannot feed themse to safety, comfort a Not standing over r with meals." Suggested method nursing (DON) or d for all staff on the p assisting at mealtin could audit dining r the policy is being f provided a dignified	ere was space by the table to assistance to eat her st on 7/22/15, at 9:20 a.m. d standing as he fed R38 her nd thickened beverages. R38 idents in the dining room at the mple chairs and space to sit o eat. re interviewed on 7/23/15, at h stated it was best to sit while t in order to be at eye level. registered nurse (RN)-C was 8/15, at 3:22 p.m. She es staff would stand when they om one resident to the next, vel was the preferred method		DEFICIENCY weeks then monthly. Nurs will perform immediate " ir upon identification of error opportunities for improven The audit will be reviewed committee and decisions if further audits needs. The Director of Nursing / I responsible to maintain co Date of Complettion Sept	sing personnel n - time" training rs or nent. I by the QA made about Designee is ompliance.	

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
		00923	B. WING		07/23/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ERENI	TY CARE CENTER - V		RENCE STI EAR LAKE,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
21810	Continued From pa	uge 39	21810		
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810		9/1/15
	medical and person needs. Appropriate care designed to en highest level of phy This right is limited	e the right to appropriate nal care based on individual e care for residents means nable residents to achieve their rsical and mental functioning. where the service is not blic or private resources.			
	by: Based on observative review, the facility for within reach for use R38, R264), review for assistance from Findings include: During an interview p.m., R378's call lig around the right grasse seated in a recliner room, on the opposite recliner was recliner	ent is not met as evidenced ion, interview and document ailed to ensure call lights were e for 3 of 4 residents (R378, red who utilized their call lights staff. with R378 on 7/20/15 at 6:23 ght was observed wrapped ab bar on the bed. R378 was on the other corner of the site side of the bed. R378's ed back. When asked if she r call light R378 stated "yes."		The Facility policy/procedure title : "Answering Call Light" was reviewed 9/1/2015 Staff have been re-educated on the policy/procedure for ensuring call lig are within reach for residents use. 9/1/2015 Call light audits will be conducted randomly throughout 24 hour period members of nursing staff and IDT. training will be conducted upon identification of errors, or oppotunitie improvement.	hts s by In-time
	the hallway calling her hands. R378 w her room and the c reach. When the su needed, R378 state toilet and needed h	0/15, R378 was heard from out "help, help" as she waved as still seated in the recliner in all light remained out of urveyor asked what R378 ed she wanted to go to the elp. The surveyor summoned ssistant (NA)-C responded.		The Audit results will be reviewed by QA committee and decisions made further audit needs. The Director of Nursing/designee is responsible to maintain compliance. Date of Completion: Sept. 1, 2015	about

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00923	B. WING		07/	23/2015
	PROVIDER OR SUPPLIER	WHITE BEABLAK 1891 FLC	DRESS, CITY, ST	ET		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC	WHITE B ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	EAR LAKE, MI	N 55110 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
21810	facility visiting and R378 without inform During this observa- able to use the call At 7:11 p.m. on 7/2 also stated R378 w call light. RN-B sta staff to ensure R37 R378's Resident A 7/17/15, identified include: nonorgani- tract infection, enco- function and acute Individual Residem indicated R378 wa assistance with toil On 7/23/15, at 12:4 (DON) stated staff	s son had just been at the it appeared he had transferred ming staff when he'd left. ation, NA-C verified R378 was l light. 20/15, registered nurse (RN)-B vas cognitively able to use the ted she would have expected 78's call light was within reach. dmission Record sheet dated the resident's diagnoses to c psychosis, confusion, urinary ephalopathy, impaired renal kidney failure. R378's t Care Plan dated 7/17/15, s at risk for falls and also s continent but required staff leting. 43 p.m. the director of nursing were to make sure resident in reach every time staff was	21810			
	seated in her whee her bed, with the te closed but opened At the time of obse pants. When appro- sitting here waiting call light was obser coiled at the foot of feet behind and to she was able to us	on 7/20/15, at 6:48 p.m. to be elchair located near the foot of elevision on. R38's eyes were quickly when called by name. ervation R38 wore a gown and bached R38 stated, "I am for staff to put me to bed." The rved to be out of R38's reach, f the bed, approximately two the right of R38. When asked if e the call light when it was tated, "I can use the call light				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00923	B. WING		07/23/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ERENI	TY CARE CENTER - V	νμιτε βεδριδκ	ORENCE STRE BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21810	Continued From pa	age 41	21810			
	when I want to and waiting."	it is in reach; I get tired of				
	(LPN)-D acknowled within reach. LPN-I use call light, "some sometimes she will here, she had it (ca) p.m. licensed practical nurse dged R38's call light was not D stated, she does not always etimes she will use it; just call out. When I left her all light) in her lap. The aides t when they pulled the covers				
	diagnoses included	s, congestive heart failure, and				
	5/5/15, indicated Racommunicate need	ea Assessments (CAA) dated 38 was alert and able to Is to staffContinue to to request assistance."				
		g Assistant Care Sheet nt in reach (sic) @ [at] all				
	R264's call light con at the end of the be	s on 7/20/15, at 3:55 p.m., rd was observed on the floor, ed. When interviewed, R264 ed the call light but could not				
		essment MDS dated 5/20/15 pnitive status as 14/15.				
	revised October 20 resident is in bed o	, Answering the Call Light 10, directed "5. When the r confined to a chair be sure in easy reach of the resident."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00923	B. WING		07/23/2015	
AME OF F	PROVIDER OR SUPPLIER	4	DDRESS, CITY, S	TATE, ZIP CODE		
ERENI	Y CARE CENTER - V		ORENCE STRE BEAR LAKE, M			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF C	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLE DATE
21810	Continued From pa	age 42	21810			
	review, the facility within reach for us	tion, interview and document failed to ensure call lights were e for 3 of 4 residents (R378, ved who utilized their call lights n staff.				
	Findings include:					
	p.m., R378's call lig around the right gr seated in a recline room, on the oppo recliner was recline	w with R378 on 7/20/15 at 6:23 ght was observed wrapped ab bar on the bed. R378 was r on the other corner of the site side of the bed. R378's ed back. When asked if she er call light R378 stated "yes."				
	the hallway calling her hands. R378 w her room and the o reach. When the s needed, R378 stat	20/15, R378 was heard from out "help, help" as she waved vas still seated in the recliner in call light remained out of urveyor asked what R378 ed she wanted to go to the				
	help and nursing a NA-C stated R378 facility visiting and R378 without inform	help. The surveyor summoned ssistant (NA)-C responded. 's son had just been at the it appeared he had transferred ming staff when he'd left. ation, NA-C verified R378 was				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURV COMPLETED	
		00923	B. WING		07/	23/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
ERENI	TY CARE CENTER - V		ORENCE STRE BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	ige 43	21810			
	able to use the call	light.				
	also stated R378 w call light. RN-B stat staff to ensure R37 R378's Resident Ac 7/17/15, identified t include: nonorganic tract infection, ence function and acute Individual Resident indicated R378 was assistance with toil On 7/23/15, at 12:4	3 p.m. the director of nursing				
	(DON) stated staff	were to make sure resident in reach every time staff was				
	seated in her whee her bed, with the te closed but opened At the time of obse pants. When appro sitting here waiting call light was obser coiled at the foot of feet behind and to t she was able to use within reach R38 st	on 7/20/15, at 6:48 p.m. to be lchair located near the foot of levision on. R38's eyes were quickly when called by name. rvation R38 wore a gown and ached R38 stated, "I am for staff to put me to bed." The ved to be out of R38's reach, the bed, approximately two the right of R38. When asked is e the call light when it was ated, "I can use the call light it is in reach; I get tired of	9			
	(LPN)-D acknowled	p.m. licensed practical nurse lged R38's call light was not D stated, she does not always				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00923	B. WING	B. WING		23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
ERENI	TY CARE CENTER - V		ORENCE STRE BEAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	age 44	21810			
	sometimes she will here, she had it (ca	etimes she will use it; I just call out. When I left her all light) in her lap. The aides it when they pulled the covers				
	diagnoses included	s, congestive heart failure, and	b			
	5/5/15, indicated R communicate need	ea Assessments (CAA) dated 38 was alert and able to Is to staffContinue to to request assistance."				
		g Assistant Care Sheet ht in reach (sic) @ [at] all				
	R264's call light co at the end of the be	s on 7/20/15, at 3:55 p.m., rd was observed on the floor, ed. When interviewed, R264 ed the call light but could not				
		essment MDS dated 5/20/15 gnitive status as 14/15.				
	revised October 20 resident is in bed o	, Answering the Call Light 10, directed "5. When the r confined to a chair be sure in easy reach of the resident."	,			
	director of nursing develop, review, ar	THOD OF CORRECTION: The (DON) or designee could nd/or revise policies and ure call lights are kept within	e			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY	
		00923	B. WING	07	/23/2015
	PROVIDER OR SUPPLIER	HITE BEAR LAK 1891 FLC	DRESS, CITY, RENCE STR EAR LAKE,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
21810	educate all appropr	DON or designee could iate staff on the policies and DN or designee could develop	21810		
	compliance.	R CORRECTION: Twenty-one			
	residents shall have	ac.Bill of Rights nsive service. Patients and the right to a prompt and se to their questions and			
	by: Based on interview	ent is not met as evidenced and document review, the w up on resident grievances (R107, R5, R127).		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.	
	meeting minutes we from a representation Resident Council m indicated R5 had vo taking a long time to day and early morn	ns of Resident Council ere reviewed with approval ve of the council. The leeting minutes dated 4/15/15, biced a concern about staff o answer call lights during the ing hours. According to the irector (AD) planned to have		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	
	the director of nursi about the concern a The Resident Coun	ng (DON) speak to the group at the meeting in May of 2015. cil meeting minutes dated he administrator and DON had		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.	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		00923	B. WING		07/2	23/2015
	PROVIDER OR SUPPLIER	WHITE BEAR LAK 1891 FLC	DRESS, CITY, DRENCE STF			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21870	been present at the the group about pla minutes indicated t stressed a desire f they had identified staffing soon to he quickly. In addition resident again void assistance and ind concern with the la The Resident Cour 6/17/15, indicated concerns about ha to the bathroom. T spoken to the resid the shortage of nur the AD had told the was "looking at the R107 was interview R107 stated she ha have her call light a accidents "all the ti to get on the toilet had to wear an incu- not. The resident s "just yesterday." Nursing assistant (7/23/15, at 12:10 p mostly continent bu accidents and work The Care Area Ass indicated R107 wa wore a peri pad at plan for R107, date resident was unabl	e meeting and and spoken to ans to improve staffing. The the DON and administrator had or good service, and indicated they would ensure improved lp respond to call lights more n, the minutes indicated a red a concern of waiting for icated a family member's ck of help during meal time. Ancil meeting minutes dated R127 and R107 had voiced ving to wait "too long" for help he notes indicated the AD had lents about budget issues and rsing assistants, and indicated e residents the administrator budget now." wed on 7/23/15, at 11:59 a.m. ad waited for over an hour to answered and had experienced me" because she was not able by herself. R107 stated she ontinent pad, but would rather aid she had waited a long time NA)-A was interviewed on .m. NA-A said R107 was ut wore a pad for dribbling		Clients call light has been ch soft paddle call cord 8/20/15 Resident council meeting ad up concern form for the dep managers. Each individual p be followed up for the perso to the group if a group conce Any discrepancies will be rev weekly department manager Activity Director, Director of Designee are responsible to compliance. Date of Completition: Sept 1	Ided a follow - artment problem will n or reported ern arises. viewed at the rs meeting. nursing or maintain	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00923	B. WING		07/	23/2015
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ERENI	TY CARE CENTER - V		DRENCE STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	ge 47	21870			
		d the approaches included, e" "just in caseOwn he daytime."				
	She was not aware too long for help ha with the residents w explained the facilit for follow up on issu implement such a f could be better trace The nurse manage interviewed on 7/23 she thought the AD concerns. Social we at the same time. S process for followin voiced at resident of	-				
	concerns, dated 8/ not limited to a writi could include verba indicated when a re staff member, the s	nd procedure for resident 1/08, indicated concerns were ten grievance procedure, but al concerns. The policy esident voiced a concern to a staff member was to complete a forward it to the social nt.				
	develop and operat form to ensure time concerns. The activ voiced concerns fro	for correction: al services director could ionalize a resident concern ely follow up for resident vity director could ensure all om resident council are orrect staff member for follow				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00923	B. WING		07/23/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ERENIT	Y CARE CENTER - V		RENCE STRE EAR LAKE, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	age 48	21870			
	-	rrection: Twenty-one (21) days.				