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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ISVH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00923

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245300**

2. STATE VENDOR OR MEDICAID NO. (L2) **253342100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - WHITE BEAR LAKE**
(L4) **1900 WEBBER STREET**
(L5) **WHITE BEAR LAKE, MN** (L6) **55110**

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

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

6. DATE OF SURVEY **10/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **08/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : 10/20/2016
Kathy Sass, HPR-Dietary Specialist (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 10/20/2016
Kamala Fiske-Downing, Health Program Representative (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245300

October 20, 2016

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 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 October 14, 2016 the above facility is certified for:

138 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 138 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

An equal opportunity employer.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 20, 2016

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: Project Number S5300026

Dear Mr. McDonald:

On September 13, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 18, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on July 22, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 8, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 14, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 14, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on October 14, 2016, as of October 14, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 14, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of September 13, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 14, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 14, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 14, 2016, is

to be rescinded.

In our letter dated September 13, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 22, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 14, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245300 Y1	A. Building B. Wing Y2	10/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1900 WEBBER 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 10/14/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 10/20/2016	SIGNATURE OF SURVEYOR 31223	DATE 10/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/22/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ISVH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00923

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2. STATE VENDOR OR MEDICAID NO. (L2) **253342100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - WHITE BEAR LAKE**
(L4) **1900 WEBBER STREET**
(L5) **WHITE BEAR LAKE, MN** (L6) **55110**

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

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

6. DATE OF SURVEY **09/8/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **08/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : 9/13/2016
Kathy Sass, HPR-Dietary Specialist (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 9/30/2016
Kamala Fiske-Downing, Health Program Representative (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION **12/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 13, 2016

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, Minnesota 55110

RE: Project Number S5300026

Dear Mr. McDonald:

On August 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 22, 2016 that included an investigation of complaint number . 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 8, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 30, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 22, 2016. The deficiency not corrected is as follows:

F0334 -- S/S: D -- 483.25(n) -- Influenza And Pneumococcal Immunizations

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective September 18, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last

day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 22, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 22, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 22, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Cerenity Care Center - White Bear Lake is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 22, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 remedy be imposed:

- 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1900 WEBBER STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 9/7 - 9/8/16. The certification tags that were corrected can be found on the CMS2567B. Also there is a tag that was not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 334} SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	{F 334}		9/30/16

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

Electronically Signed | 09/22/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1900 WEBBER STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 334}	Continued From page 1 documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second	{F 334}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1900 WEBBER STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 334}	Continued From page 2 pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pneumococcal vaccines were offered to 3 of 5 residents (R165, R411, R412) whose immunization records were reviewed. In addition, the facility failed to implement policies related to guidelines for pneumococcal conjugate vaccine (PCV13) and pneumococcal polysaccharide vaccine (PPSV23) as recommended by the Centers for Disease Control (CDC). Finding include: The facility failed to offer, if appropriate, PCV13 and/or PPSV23 for R165, R411 and R412 according to the CDC and the facility plan of correction. R165 The undated Resident Face Sheet (RFS) indicated R165 was admitted to the facility on 6/8/11 and had received the PPSV23 fall of 2010. There was no indication the PCV13 (Prevnar) had been offered, received, was contraindicated and/or refused. During interview on 9/8/16, at 2:49 p.m. the director of nursing (DON) stated she was unsure	{F 334}	The facility has policies and procedures in place to ensure that before offering the influenza immunization, each resident, or the president's legal representative receives education regarding the benefits and potential side effects of the immunization; Each resident is offered the influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; The resident or the resident's representative has the opportunity to refuse immunization; and The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility has policies and procedures in place to ensure that before offering the pneumococcal immunization, each	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1900 WEBBER STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 334}	Continued From page 3 if R165 was offered the PCV13, "I don't see that she was offered it." R411 The undated RFS indicated R411 was admitted to the facility on 8/30/16. Review of R411 ' s facility Observation Report dated 8/30/16, indicated R411's pneumococcal vaccination was up to date however did not indicate when and which pneumococcal vaccines were received. A progress note dated 8/30/16, indicated R411 stated she had an influenza and pneumonia vaccine last fall, but did not remember the exact dates. Review of an admission calendar dated 9/4/16, indicated R411 was not administered a pneumococcal vaccine. There was no indication that R411 was offered, provided risks or benefits and/or education for pneumococcal vaccine(s). R412 The undated RFS indicated R412 was admitted to the facility on 9/1/16. Review of R412's facility Observation Report dated 9/1/16, indicated R412's pneumococcal vaccination was up to date, however did not indicate when and which pneumococcal vaccines were received. The report further indicated a pneumococcal vaccine was offered and declined, however did not indicate which pneumococcal vaccine was offered. There was no indication R412 was provided risks or benefits and/or education for pneumococcal vaccine(s). During interview on 9/8/16, at 2:49 p.m. registered nurse (RN)-A stated she was not sure if R411 was offered the pneumococcal vaccine(s) or not. RN-A stated although R412 was interviewed and said she was up to date, there was no indication that she was offered "it. "	{F 334}	resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; Each resident is offered the pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; The resident or the resident's representative has the opportunity to refuse immunization; and The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindications or refusal. As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. The Administration of Prevnar 13, Pneumovax 23 policy has been reviewed, revised, and implemented. Licensed staff have completed a review of all residents and have offered, if appropriate, the pneumococcal conjugate vaccine (PCV13), including R165. R411	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1900 WEBBER STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 334}	Continued From page 4 During interview on 9/8/16, at 2:49 p.m. the DON stated the information for both R411 and R412 was vague and did not indicate if they had been offered a pneumococcal vaccine and/or which one. Review of the facility Benedictine Health System, Cerenity Senior Care-White Bear Lake policy on Administration of Prevnar 13, Pneumovax 23 dated 8/16, indicated "upon admission and throughout a resident's stay at Cerenity, education monitoring, and administration of Prevnar 13 and/or Pneumovax 23 will be provided; if the resident and/or responsible party refuse administration of Prevnar 13 and or Pneumovax 23 vaccine, document in the medical record: education and resource material provided to discuss risks of non-administration of vaccination and if medically contraindicated or if the resident was already vaccinated and is up to date with vaccination, document medical contraindications or dates of vaccination administration in the resident's medical record in the immunization section."	{F 334}	and R 412 have discharged from the facility. All new admissions will be offered the pneumococcal conjugate vaccine (PCV13). Type of vaccine, consent to administer or refusal to receive will be documented in the client's electronic medical record. Those that have given consent have had the vaccination ordered from the pharmacy. Upon delivery of the vaccination from the pharmacy, licensed staff will administer the vaccine to those that gave consent to receive. Education has been provided to all licensed staff, this education occurred on 8/30, 8/31, and 9/1. Further education and instruction of procedure was provided to licensed staff 9/13/16. Ongoing just in time training will be provided by DON, ADON, Staff Development, and nurse managers as noted to be appropriate. New nursing staff will receive education regarding vaccination policy at new employee orientation. DON or designee will ensure and monitor compliance. Clinical managers will maintain a log tracking all new admissions, offering and acceptance of Prevnar, and ensure that documentation is completed in the electronic medical record. This log will be maintained on a daily basis. In addition, 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month by DON or designee. Audits will be reviewed and re-evaluated by Quality Council. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1900 WEBBER STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 334}	Continued From page 5	{F 334}	on-going monitoring/auditing after analysis.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245300 Y1	A. Building B. Wing Y2	9/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1900 WEBBER 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278	Correction	ID Prefix F0280	Correction	ID Prefix F0314	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25(c)	Completed
LSC	08/30/2016	LSC	08/30/2016	LSC	08/30/2016
ID Prefix F0323	Correction	ID Prefix F0353	Correction	ID Prefix F0356	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.30(a)	Completed	Reg. # 483.30(e)	Completed
LSC	08/30/2016	LSC	08/30/2016	LSC	08/30/2016
ID Prefix F0371	Correction	ID Prefix F0428	Correction	ID Prefix	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.60(c)	Completed	Reg. #	Completed
LSC	08/30/2016	LSC	08/30/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	KS/mm	09/12/2016	31223	09/08/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/22/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245300	A. Building 01 - MAIN BUILDING 01 B. Wing	9/12/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1900 WEBBER 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 08/30/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 9/13/2016	SIGNATURE OF SURVEYOR 37009	DATE 9/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/20/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245300 (Y1)	A. Building 02 - 2013 ADDITION B. Wing (Y2)	9/12/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1900 WEBBER 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 08/30/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 9/13/2016	SIGNATURE OF SURVEYOR 37009	DATE 9/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/20/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ISVH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00923

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245300**

2. STATE VENDOR OR MEDICAID NO. (L2) **253342100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - WHITE BEAR LAKE**
(L4) **1900 WEBBER STREET**
(L5) **WHITE BEAR LAKE, MN** (L6) **55110**

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

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

6. DATE OF SURVEY **07/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **08/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : 08/19/2016 (L19)
Amy Charais, HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/31/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 5, 2016

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: Project Number S5300026

Dear Mr. McDonald:

On July 22, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

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

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

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

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

DEPARTMENT CONTACT

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

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 August 31, 2016, 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 August 31, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (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 22, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1900 WEBBER STREET WHITE BEAR LAKE, MN 55110

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		8/30/16

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

Electronically Signed | 08/18/2016

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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F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents (R11) reviewed for MDS accuracy. Findings include: R11's admission MDS dated 2/19/16, was coded to indicate R11 had no stage 1 (non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators) or greater, a scar over bony prominence, or a non-removable dressing/device. However, during review of the discharge MDS dated 3/16/16, when R11 was sent to the hospital it was revealed the MDS had been coded healed pressure ulcers had been in the prior MDS assessment which was not accurate. During further review of the discharge MDS dated 3/16/16, it was revealed the MDS had been coded to indicate R11 had two stage two pressure ulcers even though on 3/13/16, the wound on left heel had been noted to have eschar 2.5 cm by 3 cm (unstageable (full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the	F 278	The facility has policies and procedures in place to assure that the assessment accurately reflects the resident□s status. A RN must conduct or coordinate each assessment with the appropriate participation of health professionals. A RN must sign and certify that the assessment is completed. Each individual that completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, and individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $ 1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $ 5,000 for each assessment. RAI Manual for section M was reviewed for proper procedure for MDS Nurses to follow for gathering data for the MDS□. MDS Nurses have completed a review of MDS□ for all residents with wounds and	

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F 278	Continued From page 2 damage cannot be estimated until these are removed). In addition, on 3/15/16, "wounds to bilateral buttocks (Left side 1 centimeter (cm) by 1 cm x 0.1 cm with surrounding redness due to moisture, right buttock 2 cm by 3 cm by 0.1 cm chafed area, pink peri-wound as well had been noted which were not staged. All of the interdisciplinary notes and assessments completed inconsistently lacked information for drainage status, location and bed status, surrounding tissue health and wound staging. In addition the measurements were not indicated in the MDS. On 7/22/16, at 2:55 p.m. registered nurse (RN)-B confirmed the wounds documented in the interdisciplinary notes and the assessments completed were located in the left heel and sacral areas and not on the right heel as documented at times. RN-B stated she was not working at the unit the time of R11's stay. RN-B acknowledged the wound documentation was not accurate on some instances. -At 3:06 p.m. RN-B stated she would have expected wounds assessed appropriately and staged. RN-B stated the MDS coordinator did the initial care plan and ideally, it was the responsibility of the unit clinical manager to update the care plans after 21 days with any changes. -At 3:14 p.m. RN verified the MDS had not been coded properly to reflect the wounds from the 14 day to the discharge MDS's. RN-B stated, "Clearly we both know this is a problem." RN-B stated the staging was done 3/12/16, which was after the MDS dated 3/9/16, and that should have been reflected in the discharge MDS. On 7/22/16, at 3:42 p.m. the director of nursing	F 278	have corrected or updated where appropriate. R11 has discharged from the facility, 14D MDS has been corrected and resubmitted to CMS. MDS nurses will be auditing 5 random MDS□ per month on each other per a list that will be set up by the DON or ADON. Education will be provided for all licensed nursing personnel, to ensure understanding of the process of finding new or worsening pressure ulcers and staging of wounds. MDS nurses have been educated on the process for completing section M of the MDS as well as gathering data for completing the MDS. Licensed staff meeting is set up for August 25th for staff education on the Plan of Correction. Education on Wound Management is being completed on August 22, 2016 by Julie Ligday, ARNP WCC for all licensed nursing staff. New nursing staff will receive education regarding process for finding a new or worsened pressure ulcer and staging of wounds during new employee orientation. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month and reevaluate at Quality Council. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis.	

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F 278	Continued From page 3 (DON) stated she would expect the MDS to reflect the current resident status, which included the wound status including the staging and characteristics. According to the Long Term Care Facility Resident Assessment Instrument User's Manual 3.0 revised in October 2015, the "Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices. Changes in tissue characteristics over time are indicative of wound healing or degeneration." The manual directs staff to examine the wound bed or base of each pressure ulcer to determine the types of tissue in the wound bed. The manual indicated a "None of the above" response is used only in the following situations: a stage one pressure ulcer, a stage two pressure ulcer with intact blister, and an unstageable pressure ulcer related to non-removable dressing/device or a suspected deep tissue injury. None of the situations were relevant to R11's pressure ulcers.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		8/30/16

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F 280	Continued From page 4 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the comprehensive care plan for 1 of 2 residents (R244) to include identification and interventions for pressure ulcers. Findings include: R244 was admitted on 6/28/16, and had diagnoses that included femur fracture, diabetes, end stage renal disease and anxiety obtained from the undated Resident Face Sheet. Review of the admission Skin Risk Assessment dated 6/28/16, indicated no evidence of stage 1 or higher pressure ulcers with a Braden score of 19. Review of the weekly Skin Risk Assessment dated 7/5/16, indicated no evidence of stage 1 or higher pressure ulcers with a Braden score of 19, surgical wound care and applications of ointments/medications other than to feet. The Admission Minimum Data Set (MDS) dated 7/5/16, indicated R244 had moderate cognitive impairment, was non-ambulatory and required	F 280	F280 SS=D Right to Participate Planning Care Revise CP The facility has policies and procedures in place to verify that the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State-participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by the interdisciplinary team, a that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident□s needs, and, to the extent practicable, the participation of the resident, the resident□s family or the resident□s legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. The policy Care Plans Comprehensive has been reviewed and is appropriate. Licensed staff have completed a review of all clients with wounds to ensure that	

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F 280	Continued From page 5 extensive assistance with bed mobility, transfers and toileting. The Care Area Assessment (CAA) dated 7/5/16, indicated R244 was at risk for developing pressure areas due to recent hospitalization for fall with right hip fracture, experiencing increased weakness and decreased mobility and required assist of two with bed mobility and to turn and reposition as needed. The care plan for R244 had not been revised to reflect new open areas which were first identified on 7/13/16. The care plan did not include any revision to the interventions to prevent further breakdown and to promote healing. Review of the weekly Skin Risk Assessment dated 7/12/16, indicated no evidence of stage 1 or higher pressure ulcers with a Braden score of 20, surgical wound care and pressure reducing device for bed. The Individual Resident Care Plan initiated within 24 hours of Admission dated 6/28/16 indicated an incision on the right hip and Braden (scale for prediction of pressure sore risk) score of 19 (score of 19 or higher indicates the resident was not at risk and no interventions necessary at this time). The Cerenity Care Center Plan of Care dated 7/12/16 indicated R244 was at risk for pressure ulcers due to recent hospitalization for a fall with right hip fracture, increased weakness and decreased mobility. The care plan outlined interventions of weekly skin inspection, avoidance of shearing R244's skin during positioning, transferring, and turning, use pressure reducing	F 280	identification and interventions are accurate and up to date in their care plans. R244 has discharged from the facility. Education will be provided to all licensed nursing personnel, to ensure understanding of the process of finding a new pressure ulcer, implementing interventions and care plan updating. Licensed staff meeting is set up for August 25th, 2016. New nursing staff will received education regarding process for finding a new pressure ulcer, implementing interventions and care plan updating in new employee orientation. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month and reevaluate at Quality Council. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis.	

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F 280	Continued From page 6	F 280		

cushion in the chair and bed but did not indicate any issue with pressure ulcers.

Review of nursing progress notes indicated:
-7/5/16 "red area to the coccyx, applied skin barrier cream which pt [patient] reported was helpful. Will pass on to am nurse and continue to monitor."
-7/12/16 "able to make needs known, using w/c [wheelchair] for mobility. Raw and painful bottom, calmo applied. Scheduled Tylenol for pain, no PRN [as needed] given. Will continue to monitor"
-7/13/16 "PT [patient] came to nursing station this afternoon inquiring about placing padding on buttock versus barrier cream to sore buttocks. Writer with A1 [assist of one] from NAr [nursing assistant] assisted pt to stand and observed skin. Writer noting scabbed area to coccyx measuring 1.5 X 0.8 cm. No redness, drainage, or warmth noted. Writer also noted peeling skin to gluteal fold. On left side of gluteal fold writer noted to open areas measuring 0.9 X 0.5 by less than 0.1cm and 0.5 X 0.3 cm. Writer cleansed areas and patted dry. Applied foam bordered dressing for protection to coccyx. Due to skin peeling writer applied thin layer of house barrier cream and then a 4X4 gauze and secured with tape to gluteal fold. PT brought cushion from home which she has been using. Therapy notified of skin concern and stated would initiate a roho cushion. Writer providing education to pt regarding importance of repositioning frequently and when noting discomfort to buttock. PT goes to Dialysis 3x/week. Writer encouraging pt to ask for staff at dialysis to assist with repositioning and it is okay for pt to bring pillow from our facility to help with repositioning in chair during dialysis if needed. Pt appeared accepting of information provided. Call placed to family and NP [nurse practitioner] to

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F 280	Continued From page 7 update. Writer did implement nursing order for simple dressings until NP can review." -7/14/16 "two OA [open areas] on coccyx and left buttock. Foam dressing but no gauze applied. Sitting tolerance scheduled for tomorrow." -7/16/16 "New tegaderm-foam dressing applied to two o/a's on buttocks, is turned and repositioned q [every] 2 hrs [hours] and prn, A1 w/cares and transfers, is continent." -7/19/16 "the majority of patient's skin was intact with exception of open area on coccyx-old drg [dressing] removed (no drainage noted). Two areas of concern: first to the top of the coccyx toward the right side is an area approximate 1.0 X 1.0, but remains superficial; and second area on the left side of the buttock, this is irregular shaped and feels like mostly scar or scab tissue & is approximate 1.5cm X 1.5cm. Mepilex dressings on both areas." -7/20/16 "Foam boarder [sic] dressing was changed to coccyx today and measured (0.8CM X 0.5CM)." During interview on 7/22/16, at 1:03 p.m. RN-(C) stated resident recently had dressing to the coccyx initiated, repositioning and a cushion is on her wheelchair. RN- C stated when residents first come a clinical assessment is conducted immediately and a skin check is conducted by the night nurse and the assessment did not indicate any issues. During interview on 07/22/2016, at 1:09 p.m. R244 stated she had sores on her "behind" when she was in the hospital recently, but they "come and go." During interview on 7/22/16, at 1:11 p.m. LPN-(B) stated she uses the temporary care plan and	F 280		

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F 280	Continued From page 8 verified that neither pressure ulcers or dialysis was noted on the care plan but were in the treatment orders. LPN-B stated she was aware of a coccyx pressure ulcer. During interview on 7/22/16, at 2:06 p.m. RN-(B) stated R244 had a scabbed area on her coccyx and open areas on her left buttock when she evaluated R244 on 7/13/16. RN-B stated she had not completed a pressure ulcer measurement since 7/13/16, the floor nurses measure the pressure ulcers. RN-B stated they use a temporary care plan until day 21 and would have updated it "this week" to include any changes with the resident which would include dialysis, pressure ulcers, poor appetite, "things like that." Review of the facility Goals and Objectives, Care Plans policy with revision date of April 2009 indicated that care plan goals and objectives are defined as the desired outcome for a specific resident problem and entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. Goals and objectives are to be reviewed and/or revised when there has been a significant change in the resident's condition, when desired outcome has not been achieved, when the resident has been readmitted to the facility from a hospital/rehabilitation stay and at least quarterly.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		8/30/16

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F 314	Continued From page 9 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to document staging and characteristics of wound(s) for 3 of 3 residents (R11, R353, R244) reviewed for pressure ulcers. Findings include: R11's care plan dated 1/27/16, indicated resident has a pressure ulcer related to home self-care deficit. The care plan identified resident had a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) on the left hip. The care plan directed staff to assess and record the condition of the skin surrounding the pressure ulcer. Staff were to assess the pressure ulcer for location, stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization every week. The Admission Minimum Data Set (MDS) dated 2/19/16, indicated R11 had intact cognition and relied on staff for all total assistance with activities of daily living. R11's diagnoses included diabetes mellitus, displaced intertrochanteric fracture of left femur, muscle weakness, osteoarthritis and unsteadiness of feet obtained from the admission MDS dated 2/19/16. The MDS noted R11 was re-admitted to the facility on 2/12/16.	F 314	F314 SS=D Pressure Sores The facility has policies and procedures in place to ensure that based on the comprehensive assessment a resident that enters the facility without pressure sores does not develop pressure sores unless the individual□s clinical condition demonstrates that they were unavoidable; and a resident having pressures sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Pressure Ulcer Risk Assessment Policy, Pressure Ulcer Treatment Policy and Prevention of Pressure Ulcers Policy have been reviewed and are deemed appropriate. R11, R244 and R353 have discharged from the facility. A review of all residents with wounds in house for documentation required has been completed and all residents requiring updates have been completed. Review of all residents admitted with a pressure ulcer on coccyx and a reassessment of B&B if on coccyx to identify patterns of incontinence to ensure skin remains dry and to be sure frequency is noted if a check and change program or a toileting program is used has been completed. A	

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F 314	Continued From page 10 The Pressure Ulcer Care Area Assessment (CAA) dated 2/19/16, indicated the CAA had triggered related to resident being at risk for developing pressure areas due to recent hospitalization for fall with left hip fracture with increased weakness and decreased mobility. The CAA directed staff to provide extensive assist of two with bed mobility to lift legs into bed, boost up, turn and reposition every two hours while in bed. The Skin Assessment w/Braden Scale (a scale used to predict pressure sore risk) *R dated 2/20/16, indicated R11 did not have one or more unhealed pressure ulcer(s) at stage 1 (nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators) or higher. In addition, the assessment indicated resident was at risk for pressure ulcers and required extensive assist and did not reposition himself much and needed to be turned and repositioned whenever in bed. The Skin Integrity Events-Impaired Skin Integrity dated 2/23/16, indicated resident had a blister on the left heel with measurements 2 inch by 2 inch, blister was intact and etiology was pressure and skin and ulcer treatments put in place were to elevate affected extremity and skin prep. The assessment lacked the stage of pressure ulcer. On 2/24/16, the Nursing Progress Note indicated, "As writer was putting on ointment, writer noticed a blister to [patient] pt.'s left heel. Blister is intact, 2 inch X 2 inch. Skin prep placed to bilateral heels, both heels floated on pillows overnight.	F 314	Review all residents in house that are at risk for skin breakdown to be sure all have a Tissue Tolerance completed , recent and that all care plans reflect risk and have interventions in place has been completed. Education will be provided for all licensed nursing personnel on August 22, 2016 for Wound Management. Additional education for all licensed staff will occur on August 25, 2016 and will include: process of finding new or worsening pressure ulcers, staging of wounds, documentation required, interventions available and put in place and the 3M Protocol to be used. New nursing staff will receive education regarding process for finding a new or worsened pressure ulcer, staging of wounds, documentation required, interventions and 3M Protocol during new employee orientation. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month and reevaluate at Quality Council. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis.	

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Dressing to left hip changed, incision is CDI [clean, dry, intact] and stapled, left hip area is moderately red and warm. Will update AM [morning] nurse in morning. Pt. [patient] in bed at this time." On 2/26/16, at 10:45 p.m. note indicated moderate amount of reddish-yellow drainage on old dressing from blister area on left foot heel area with non-adherent dressing with Kerlix (gauze dressing) applied and heels floated. On 2/26/16, at 5:33 p.m. indicated the doctor had seen the open blister to resident left heel and gave new orders.

The care plan dated 2/26/16, indicated resident was at risk for pressure ulcers related to recent hospitalization for fall with left hip fracture, had increased weakness and decreased mobility. The care plan directed staff to conduct a systematic skin inspection weekly on bath day, observe daily during routine cares and pay particular attention to the bony prominences. The care plan was void of any documentation which identified the left heel as having a pressure ulcer.

The Skin Integrity Events-Pressure Sore/Stasis Ulcer dated 3/3/16, indicated non blanchable redness noted to sacral area in two areas in which both measured 1 inch by 1 inch and immediate interventions turning/repositioning program, cradle blanket and heel protectors. The assessment lacked the staging of the pressure ulcer (the care plan dated 2/26/16, was void of any documentation which identified a pressure ulcer in the sacral area).

The Skin Assessment w/Braden Scale *R dated 3/5/16, indicated resident had one stage II, one stage II pressure ulcer had worsened since prior assessment, and that the one stage II pressure

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ulcer had healed that had been noted on the previous assessment. In addition, the assessment indicated the Braden score was 18 (at risk) post status left hip fracture and had developed a blister on the left heel, which was draining and was on antibiotic for an infection. The assessment did not provided the pressure ulcer wound characteristic and location.

The Nursing Progress Notes dated 3/9/16, indicated the right heel pressure sore was assessed and the dressing changed dressing. The wound was dark red with no apparent odor, and no blisters noted. The heels were floated with no pain noted related to pressure wound. The wound was non-blanchable redness on sacrum. On 3/10/16, indicated the right heel was assessed and the dressing changed. The wound was black with a faint odor. Also assessed was the sacrum, noted red non-blanchable area about quarter size on left buttocks. On 3/10/16, the note indicated the dressing to left heel was changed. The wound bed appeared necrotic with a black area that measured 3.0 cm by 2.5 cm. The resident was seen that day by the doctor who directed staff to measure black area with dressing changes and doctor was updated regarding wound to left buttock however, no new orders. On 3/11/16, indicated the dressing to left heel was changed, and the area of eschar (composed of necrotic granulation tissue, muscle, fat, tendon or skin. The term stable eschar is used to describe leathery, dry hard eschar tissue, such as the eschar that commonly forms on the heels or other bony prominences of the lower leg) measured 3.0 cm by 2.5 cm, skin prep was applied to heels, and the heels were floated overnight. On 3/11/16, wound care note indicated an unstageable circular ulcer (full-tissue thickness loss in which

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F 314	Continued From page 13 the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed) present to left heel which measured 3.5 cm by 2.6 cm. The area of eschar measured 2.9 cm by 2.4 cm. "Eschar is firm to touch. Wound bed is dry; 10 percent healthy granulation tissue present to wound bed with defined edges. Surrounding tissue is firm. No odor. No indications of infection. Skin prep applied to wound and surrounding tissue. Dry ABD [abdominal] pad placed and wrapped with Kerlix. Also circular blanchable redness to right inner buttock and dime sized area of macerated tissue to left inner buttock." On 3/12/16, indicated the wound on left heel had small amount of drainage, eschar 3.0 cm by 2.5 cm, skin intact around edges, applied skin prep to both heels, nonstick dressing and Kerlix was applied to left heel, and both heels were floated. Powder was applied to groin area to keep skin dry, Calmoseptine ointment (multipurpose moisture barrier that temporarily relieves discomfort and itching) applied to sacral area for stage II pressure area healing. On 3/12/16, indicated no new changes noted to resident previous documented skin problem to sacrum which had a small open area, reddened, and non-blanchable. Dressing change was done to left heel, and the area measured eschar 2.5 cm by 3.0 cm, previous dressing had scant yellow tinged drainage. On 3/12/16, dressing to right heel changed. The wound had scant yellow drainage and had a faint foul odor. The wound was circular, slightly yellow, and black and measured 2.5 cm by 3.0 cm. The Skin Assessment w/Braden Scale *R dated 3/12/16, indicated the assessment had been completed as a weekly Braden assessment, it	F 314		

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identified R11 had one stage I pressure ulcer, two stage II pressure ulcers and one stage II pressure ulcer had worsened since prior assessment. Even though, the assessment identified the staging of pressure ulcers; the characteristics and location were not identified.

Review of nursing progress notes indicated on 3/13/16, the resident's dressing to heel was changed, there was scant yellow drainage on old dressing, eschar of heel measured 2.5 cm by 3.0 cm. On 3/13/16, the wound on left heel continued to have eschar 2.5 cm by 3 cm. The dressing was changed, and was wrapped with Kerlix. The Duoderm (a wound product used to treat bed sores. Hydrocolloid dressings have gel-like properties to absorb excretions from the wound and protect the wound debris and potentially infection causing bacteria) on sacral wound clean, dry, and intact. On 3/14/16, a Duoderm patch on sacrum was clean, dry, and intact with no signs of infection present. On 3/15/16, "wounds to bilateral buttocks (Left side 1 centimeter (cm) by 1 cm x 0.1 cm with surrounding redness due to moisture, right buttock 2 cm by 3 cm by 0.1 cm chafed area, pink peri-wound as well--cleansed, dried--applied hydrocolloid dressing. Area to left heel approximately 4 cm in circumference with eschar. Eschar base had pulled away from inferior border some resulting in small amount of yellow serosanguinous drainage on gauze re-dressed." All of the interdisciplinary notes and assessments completed inconsistently lacked information for drainage status, location and bed status, surrounding tissue health and wound staging. In addition the documentation was inconsistent with the actual location of the pressure ulcer on the left heel as it was referred to being on the right

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F 314	Continued From page 15 heel. R11was discharged from the facility to the re-admitted back to the hospital on 3/16/16, according to the discharge MDS dated 3/16/16. On 7/22/16, at 2:55 p.m. registered nurse (RN)-B confirmed the wounds documented in the interdisciplinary notes and the assessments completed were located in the left heel and sacral areas and not on the right heel as documented at times. RN-B stated she was not working at the unit the time of R11's stay. RN-B acknowledged the wound documentation was not accurate on some instances. -At 3:06 p.m. RN-B stated she would have expected wounds assessed appropriately and staged. RN-B stated the MDS coordinator did the initial care plan and ideally, it was the responsibility of the unit clinical manager to update the care plans after 21 days with any changes. -At 3:14 p.m. RN verified the MDS had not been coded properly to reflect the wounds from the 14 day to the discharge MDS's. RN-B stated, "Clearly we both know this is a problem." RN-B stated the staging was done 3/12/16, which was after the MDS dated 3/9/16, and that should have been reflected in the discharge MDS. On 7/22/16, at 3:42 p.m. the director of nursing (DON) stated she would expect the MDS to reflect the current resident status, which included the wound status including the staging and characteristics. At 3:45 p.m., DON further stated "We need to do more education there" when asked if the clinical nurse manager or nurses were supposed to assess and complete wound documentation to include staging and	F 314		

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F 314	Continued From page 16 characteristics. The nursing assistants that worked that unit during R11's stay were not available for interview. The weekly skin inspection on bath days for R11 was requested however, they were not provided. R353's Admission MDS dated 7/17/16, indicated she was moderately cognitively impaired, required extensive assistance with bed mobility, toileting and transfers and was incontinent of bowel and bladder. Her care plan, undated, identified a high risk for pressure ulcers due to a pressure ulcer on her coccyx present on admission to the facility. The care plan directed staff to reposition R353 every two hours. The care plan further indicated a check and change program for toileting, but did not identify a frequency. A Cerenity Care Center White Bear Lake Admission Skin Condition/New Wound Assessment dated 7/10/16 indicated R353 had a pressure ulcer on her coccyx and a round calloused area on her left heel. A Cerenity Care Center - White Bear Lake Observation Report dated 7/13/16, indicated R353 had one stage one pressure ulcer and one stage two pressure ulcer present on admit or re-admit. The observation did not identify characteristics of the wound. A review of Cerenity Care Center- White Bear Lake Resident Progress Notes dated 7/10/16 through 7/22/16, indicated the following: On 7/10/16, R353 admitted to the facility following a right hip fracture. On 7/11/16, the pressure ulcer on coccyx measured, dressing intact. Callouses were noted on bilateral plantar section of feet. On	F 314		

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F 314	Continued From page 17 7/12/16, the interdisciplinary team (IDT) discussed open area to coccyx in which the patient was admitted with. Staff were directed to assist with repositioning every two hours. On 7/12/16, R353 was incontinent of bladder two times. The right heel was purplish in color and tender to touch. The dressing was intact to coccyx ulcer. On 7/13/16, the resident was sent to the hospital for evaluation of right foot and pain. R353 returned the same evening from hospital. The pressure ulcer to right heel presented as a blister. On 7/16/16, the resident was incontinent of bowel and bladder that shift. The dressing was replaced to the coccyx, proximal wound was open with clear drainage, smaller sore on left buttock. The surrounding tissue was discolored and non- blancheable. On 7/18/16, the area to coccyx had two wounds right next to each other measuring 2.2 cm x 3.4 cm and 1.8 cm x 2.7 cm. An order was obtained to cleanse the wound daily and measure on Mondays. On 7/20/16, the coccyx appeared to worsen. The coccyx now measured 2.3 cm x 2.5 cm, to the right distal area maceration continued with two new open areas irregular in shape measuring 2.3 cm x 1.2 cm and another small area. The facility ' s team sheet was updated to ensure patient was checked and changed every two hours day and night related to incontinence. On 7/21/16, the right heel blister remained intact and measured 3 cm x 3.5 cm. During an interview on 7/21/16, at 3:03 p.m., RN-G stated R353 has poor skin integrity. She stated she had two "moisture Ulcers" on her coccyx with a bridge in between. RN-G stated both ulcers have slough (slough is dead tissue, usually cream or yellow in color and indicates a stage III pressure ulcer.) She stated R353 was	F 314		

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admitted with one ulcer, but it had gotten worse. RN-G stated she started R353 on a new toileting plan of every two hours and stated previously she had been on every four hour check and change program because "most people don't wet every two hours." She further stated R353 had an intact blister on her heel that she stated was pressure related.

During an interview on 7/22/16, at 10:32 a.m., RN-B stated R353 was admitted with one stage II pressure ulcer on her coccyx. She stated she looked at her heels on admission and there was no redness and stated R353 did not have pressure ulcers on her heel on admission, RN-B stated R353 went out to the hospital and returned with the ulcer on her heel. However, R353 went to the hospital at approximately 10:00 a.m. and returned the same day at approximately 6:30 p.m. She further stated R353 was incontinent and should have had a bladder assessment completed, but the assessment was not done.

While the facility identified and measured R353's pressure ulcers, there was no evidence of wound staging, nor was there any description of the wound characteristics noted. Further, while the facility identified a risk for pressure ulcers related to a coccyx ulcer present on admission and while R353 was incontinent of both bowel and bladder, there was no re-assessment completed to identify patterns of incontinence to ensure R353's skin remained clean and dry.

R244 was observed on 7/21/16, at 10:58 a.m. dressed, sitting on a cushion in a wheelchair at the dining room table waiting for lunch. R244 stated everything was fine, "The food is really good here. I have gained weight."

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F 314	Continued From page 19 R244 was admitted on 6/28/16, and had diagnoses that included femur fracture, diabetes, end stage renal disease and anxiety obtained from the undated Resident Face Sheet. The Individual Resident Care Plan initiated within 24 hours of Admission dated 6/28/16, indicated an incision on the right hip and Braden score of 19 (score of 19 or higher indicates the resident was not at risk and no interventions necessary at this time). Review of the admission Skin Risk Assessment dated 6/28/16, indicated no evidence of stage 1 or higher pressure ulcers with a Braden score of 19. Review of the weekly Skin Risk Assessment dated 7/5/16, indicated no evidence of stage 1 or higher pressure ulcers with a Braden score of 19, surgical wound care and applications of ointments/medications other than to feet. The Admission MDS dated 7/5/16, indicated R244 had moderate cognitive impairment, was non-ambulatory and required extensive assistance with bed mobility, transfers and toileting. The CAA dated 7/5/16, indicated R244 was at risk for developing pressure areas due to recent hospitalization for fall with right hip fracture, experiencing increased weakness and decreased mobility and required assist of two with bed mobility and to turn and reposition as needed. The Cerenity Care Center Plan of Care dated 7/12/16, indicated R244 was at risk for pressure ulcers due to recent hospitalization for a fall with	F 314		

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right hip fracture, increased weakness and decreased mobility. The care plan outlined interventions of weekly skin inspection, avoidance of shearing R244's skin during positioning, transferring, and turning, use pressure reducing cushion in the chair and bed but did not indicate any issue with pressure ulcers.

Review of the weekly Skin Risk Assessment dated 7/12/16, indicated no evidence of stage 1 or higher pressure ulcers with a Braden score of 20, surgical wound care and pressure reducing device for bed.

Review of Nursing Progress Notes indicated:
-7/5/16, "Red area to the coccyx, applied skin barrier cream which pt [patient] reported was helpful. Will pass on to am [morning] nurse and continue to monitor."
-7/12/16, "able to make needs known, using w/c [wheelchair] for mobility. Raw and painful bottom, calmo [Calmoseptine] applied. Scheduled Tylenol [a mild analgesic] for pain, no PRN [as needed] given. Will continue to monitor"
-7/13/16 "PT [patient] came to nursing station this afternoon inquiring about placing padding on buttock versus barrier cream to sore buttocks. Writer asked if it would be okay to assess buttock, which pt agreed. Writer with A1 [assist of one] from NAr [nursing assistant] assisted pt to stand and observed skin. Writer noting scabbed area to coccyx measuring 1.5 X 0.8 cm. No redness, drainage, or warmth noted. Writer also noted peeling skin to gluteal fold. On left side of gluteal fold writer noted to open areas measuring 0.9 X 0.5 by less than 0.1cm and 0.5 X 0.3 cm. Writer cleansed areas and patted dry. Applied foam bordered dressing for protection to coccyx. Due to skin peeling writer applied thin layer of

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house barrier cream and then a 4X4 gauze and secured with tape to gluteal fold. PT brought cushion from home which she has been using. Therapy notified of skin concern and stated would initiate a ROHO cushion. Writer providing education to pt regarding importance of repositioning frequently and when noting discomfort to buttock. PT goes to Dialysis 3x/week. Writer encouraging pt to ask for staff at dialysis to assist with repositioning and it is okay for pt to bring pillow from our facility to help with repositioning in chair during dialysis if needed. Pt appeared accepting of information provided. Call placed to family and NP [nurse practitioner] to update. Writer did implement nursing order for simple dressings until NP can review."
-7/14/16 "two OA [open areas] on coccyx and left buttock. Foam dressing but no gauze applied. Sitting tolerance scheduled for tomorrow."
-7/16/16 "New Tegaderm-foam dressing applied to two o/a's on buttocks, is turned and repositioned q [every] 2 hrs [hours] and prn, A1 [assist of 1] w/cares and transfers, is continent."
-7/19/16 "the majority of patient's skin was intact with exception of open area on coccyx-old drsg [dressing] removed (no drainage noted). Two areas of concern: first to the top of the coccyx toward the right side is an area approximate 1.0 X 1.0, but remains superficial; and second area on the left side of the buttock, this is irregular shaped and feels like mostly scar or scab tissue & is approximate 1.5cm X 1.5cm. Mepilex dressings [a foam dressing] on both areas."
-7/20/16 "Foam boarder [sic] dressing was changed to coccyx today and measured (0.8CM X 0.5CM)."

Review of the Nurse Practitioner Follow-up visit dated 7/14/16, indicated "recently noticed a

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minimal pencil eraser sized superficial coccyx wound probably received at dialysis secondary to sitting for long period of time and will add skin prep along with a dressing to that daily."

During interview on 7/22/16, at 1:03 p.m. RN-C stated resident recently had dressing to the coccyx initiated, repositioning and a cushion is on her wheelchair. RN-C stated when residents first come a clinical assessment is conducted immediately and a skin check is conducted by the night nurse and the assessment did not indicate any issues.

During interview on 7/22/16, at 1:09 p.m. R244 stated she had sores on her "behind" when she was in the hospital recently, but they "come and go."

During interview on 7/22/16, at 1:11 p.m. LPN-B stated she uses the temporary care plan and verified that neither pressure ulcers nor dialysis was noted on the care plan but were in the treatment orders. LPN-B stated she was aware of a coccyx pressure ulcer.

During interview on 7/22/16, at 2:06 p.m. RN-B stated R244 had a scabbed area on her coccyx and open areas on her left buttock when she evaluated R244 on 7/13/16. RN-B stated she had not completed a pressure ulcer measurement since 7/13/16, the floor nurses measure the pressure ulcers. RN-B stated R244 did not have a pressure ulcer on admit as indicated by the initial skin assessment. RN-B stated we need to change how we do things over here, our processes need to be tightened up."

During interview on 7/22/16, at 3:06 p.m. the

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F 314	Continued From page 23 DON stated "we need to do more education" when asked if nursing should measure and stage pressure ulcer wounds. A Facility policy titled Pressure Risk Assessment, dated September 2013 identified guidelines for the assessment of resident's at risk for pressure ulcers. The policy identified feces, urine, moisture and perspiration as potential irritants that may cause a pressure ulcer to worsen. The policy directed staff to document in the patients' medical record. Review of the facility Pressure Ulcer Risk Assessment policy with revision date of September 2013 indicated a pressure ulcer risk assessment will be completed on admission and then weekly for three weeks, quarterly, annually and with significant changes. Skin assessments would be completed for the presence of developing pressure ulcers on a weekly basis, more frequently if indicated. Staff will perform routine skin inspections and nurses are to be notified to inspect the skin if skin changes are identified. The policy also indicated the at risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. The policy lacked direction on how to measure and record identified pressure ulcers.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		8/30/16

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F 323	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and implement interventions, including maintenance of equipment and fall interventions, to prevent accidents for 4 of 5 residents (R183, R287, R204 and R254) reviewed for accidents. Findings include: Equipment: On 7/19/16, at 10:21 a.m. during R183's room observation the left grab bar away from the door close to the other resident was noted to be loose. The grab bar moved back and forth one to three centimeters when touched. R183's diagnoses included Parkinson's disease, weakness, mild cognitive impairment, and anxiety disorder obtained from the electronic medication administration record (EMAR) for July 2016. R183's Restraints/Adaptive Equipment -Side Rails assessment dated 4/5/16, indicated resident had bilateral grab bars in use and continued to use both grab bars appropriately to assist with bed mobility and transfers. R183's Falls-Fall Risk (Acuity)- Balance and Functional Limitation ROM 3/14 assessment dated 4/6/16, indicated resident was at risk for falls and had mobility devices identified as walker and wheelchair. Even though both assessments	F 323	F323 SS=E Free of Accident Hazards/Supervision/Devices The facility has policies and procedures in place to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A procedure has been developed for use of T&R bars and the routine checking of them. Review of Falls Report and Assessment Policy was completed and deemed appropriate. A procedure has been developed for use by licensed nursing staff when a fall occurs. Left T&R Bars have been tightened on beds and a new Restraint/Adaptive Equipment Observation has been completed for R183 and R287. R204 had blue bolsters added to the bed on 7/20/16 evening shift. A new Restraint/Adaptive Equipment Observation has been completed for R204. A new bed has been placed for R204 on 7/22/16. All residents in house that use a T&R bar have been reviewed for stability, a new Restraint/Adaptive Equipment Observation has been completed on all of these residents for appropriateness and need. Any loose T&R Bars have been tightened if needed and checked to be sure they are attached to the bed frame appropriately. New, more sturdy T&R	

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F 323	Continued From page 25 indicated resident used grab bars in bed for mobility neither indicate how the grab bars were checked to ensure they were properly fitting/affixed to the bed frame. During review of the interdisciplinary progress notes it was revealed R183 had been identified with bruises on 4/20/16, 5/5/16, and 7/21/16, on the back of the left forearm just above wrist and right forearm and the bruising was thought to be caused by resident bumping his arms on grab bars as he would turn in bed and padding to grab bars had be applied however, no documentation was done if the grab bar had been checked to be properly affixed to the bed frame R183's Falls Care Area Assessment (CAA) dated 4/15/16, indicated resident was at risk for falls due to diagnoses of degenerative joint disease (DJD), Parkinson's disease and experienced unsteady balance. CAA indicated staff provide extensive assist with all transfers, ambulation with walker and locomotion in wheel chair. R183's quarterly Minimum Data Set (MDS) dated 7/1/16, indicated resident had severely impaired cognition. The care plan revised 7/18/16, indicated resident was limited in physical mobility secondary to Parkinson's, muscle weakness, general pain, and abnormal gait. Care plan indicated resident had bilateral grab bars to aid with bed mobility, and transfers. On 7/20/16, at 11:30 a.m. nursing assistant (NA)-A and surveyor went to room verified after touching both the grab bars attached/affixed to bed that the left one was loose. NA-A stated "yeah it's loose. I will let maintenance know.	F 323	bars have been ordered for all beds they are used for. A comprehensive review of all falls for R254 has been completed for trending. All medication orders have been reviewed by licensed staff, NP and pharmacy consultant for proper diagnosis. Side effect monitoring has been added to eTAR due to the use of an antipsychotic medication. Orthostatic blood pressures are to be monitored after each fall, three times a week and with any change to the antipsychotic medication. Interventions have been reviewed and the video monitoring has been removed. A new B&B assessment has been completed. Leadership licensed nurses will complete a comprehensive note on all falls that occur for this resident to review for possible trends. All residents with falls have been reviewed for added interventions to attempt to reduce fall risk. All interventions will be added to the care plan. Any resident with a high number of falls will be reviewed with a comprehensive note to attempt to determine trends related to falls. Education will be provided for all licensed nursing personnel on August 25, 2016 and will include the process for use of T&R bars and the routine checking of them. Education will also be provided at this meeting on the procedure developed for falls if they occur. New nursing staff will receive education regarding process for use of T&R bars and the routine checking of them and procedure of what to do if there is a fall during new employee orientation. Maintenance and	

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F 323	Continued From page 26 Thank you for letting me know." NA-A stated he had assisted R183 for the last two days with all cares and had not noticed. NA-A then was observed go to the nursing station and filled a maintenance order for the grab bar and handed it to licensed practical nurse (LPN)-A at the desk. On 7/21/16, at 2:19 p.m. LPN-A stated resident bruised easy and thought was caused by bumping on the grab bars when turning in bed and wheelchair wheels. R287's left grab bar close to door was observed during the room observation, to be loose on 7/19/16, at 10:11 a.m. The grab bar moved back and forth one to three centimeters when touched. R287's diagnoses included Alzheimer's disease and age related osteoporosis without pathological fracture obtained from quarterly MDS dated 5/27/16. In addition the MDS indicated resident had moderately impaired cognition. R287's fall CAA dated 3/7/16, indicated patient was at risk for falls. The care plan revised 6/20/16, indicated resident had limited mobility related to femur fracture with surgical fix 2/16. The care plan interventions indicated resident used bilateral grab bars to aid with bed mobility and transfers. R287's Falls-Fall Risk (Acuity)- Balance and Functional Limitation ROM 3/14 assessment dated 5/26/16, indicated resident was at risk for falls related to medications that can affect blood pressure, incontinence, and history of falls with fracture. The assessment did not indicated R287 had grab bars affixed to her bed for mobility.	F 323	Housekeeping staff have been educated on the process for checking and applying T&R bars. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month and reevaluate at Quality Council. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis.	

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During further document review, it was revealed R287 had no Restraints/Adaptive Equipment -Side Rails assessment completed and on the team assignment sheet dated 7/19/16, indicated R287 was a fall risk and frequently self transferred/ambulated.

On 7/21/16, at 10:57 a.m. NA-B verified the left grab bar was loose "it's very loose" after comparing with the one on the right side of bed. When asked if she was aware the side rail was loose, NA-B stated resident was independent and had not been to the room. NA-B stated she would complete a maintenance order for the grab bar to be fixed.

On 7/21/16, at 11:12 a.m. when R287 was asked if she used the side rail, R287 stated "I do sometimes when I get in and out of bed." When asked if the grab bar was always loose, R287 stated "It's always been loose that way and thought that was how it was supposed to be."

On 7/21/16, at 2:26 p.m. registered nurse (RN)-A verified the left grab bar was loose. When asked if there was a system for checking the grab bars were routinely to ensure they were properly affixed to the bed frame, RN-A stated "not that I know of on the nursing side. We usually put a maintenance slip for all concerns just as the staff did." RN-A directed surveyor to check with maintenance.

On 7/21/16, at 4:11 p.m. when asked what the system was for checking grab bars, the environmental services director (ESD) stated nursing called the department when a resident bed had to have grab bars and someone from his department would come and apply them to the

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bed. ESD indicated nursing was supposed to fill a maintenance order when an issue had been identified. ESD further stated house keeping was in the room weekly doing thorough cleaning and would have expected the staff to have identified the grab bar was loose. ESD acknowledged the facility did not have a good system for ensuring the grab bars were checked to ensure they were properly affixed to the bed.
On 7/20/16, at 1:55 p.m. during R204's room observation the left grab bar was noted to be loose and moved back and forth when touched. In addition, the mattress was noted to be short and a five inch gap was noted between the mattress and headboard.

On 7/20/16, at 2:40 p.m. RN-A confirmed that the grab bar outside of bed is loose and there was a 5.5 inch gap between the mattress and headboard.

On 7/21/16, at 11:08 a.m. during another follow up tour to the room the grab bar on the outside of bed continued to be loose.

R204's diagnoses included obtained history of falls, difficulty in walking and generalized muscle weakness from the Physician Order Report dated 6/22/16-7/22/16.

The quartley MDS dated 5/19/16, indicated R204 had moderate cognitive impairment and required extensive assistance with bed mobility and transfers.

On 7/21/16, at 12:03 p.m. the director of nursing (DON) stated the facility had a variety of beds and grab bars. DON stated she had been made aware of the ill fitting mattresses on the

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Transitional Care Unit (TCU) and in R204's room. DON acknowledged the blue bolsters were put in place on R204's bed the previous evening 7/20/16. DON was unable to outline the facility monitoring system to ensure loose grab bars on beds and improper fitting mattresses were checked regularly.

On 7/21/16, at 1:26 p.m. DON provided a side rail assessment for R204 dated 2/29/16, which indicated R204 used grab bars used for bed mobiity and assist with transfers. In addition the assessment indicated the bilateral grab bars in place were to to assist with transfers and resident continued to utilize bilateral grab bars appropriately. The assessment however it did not address how staff were to check the grab bars to ensure they were properly affixed to the bed.

The facility Proper Use od Side Rails policy revised October 2010, directed:
"10. The resident will be checked periodically for safety relative to side rail use...
12. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space many vary, depending on the type of bed and mattress being used)..."
Falls:

R254's admission minimum data set (MDS) dated 5/10/16 indicated he was severely cognitively impaired and required assistance with all activities of daily living. The MDS indicated he was occasionally incontinent and had a history of falls prior to admission to the facility and falls since admission to the facility.

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R254's care plan dated 7/20/16 indicated a risk for falling related to dementia, Parkinson's and depression with a goal to remain free from injury. Care planned interventions included the following: Low bed in place with sign indicating proper height, video monitoring in room, landing mat at bedside and provide toileting assist every two to three hours as well as medication changes per physician and NP (nurse practitioner) orders.

A review of R254's progress notes dated 5/3/16 through 7/21/16 identified the following:

- 5/3/16 R254 admitted to the facility.

- 5/4/16 NA (nursing assistant) alerted nurse to R254 lying on the floor in his room. A facility Event Report dated 5/4/16 indicated R254 fell at 10:35 p.m.

- 5/13/16 R254 called for help. Staff went to room and he was sitting on the floor at bed side. A facility Event Report dated 5/16/16 indicated R254 fell at 2:50 a.m.

- 5/13/16 Interdisciplinary team (IDT) note: "Spoke with resident about fall." resident stated he wanted to stand up. Reminder to use call light. Bed will be switched to a lower bed and urinal to be kept at bed side. A facility Event Report dated 5/13/16 indicated this fall occurred at 10:02 p.m.

- 5/13/16 R254 again calling out for help. Staff entered room and found him lying on the floor. R254 stated he wanted to go to the bathroom. Staff reminders to use call light. A facility Event Report dated 5/13/16 indicated this fall occurred at 10:50 p.m.

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F 323	Continued From page 31 - 5/16/16 R254 found crawling out of bed while staff was assisting room mate. A facility Event Report dated 5/16/16 indicated this fall occurred at 2:31 a.m. - 5/16/16 IDT note: Spoke with R254 about falls over the weekend. Bed was switched for a lower bed and staff spoke with the nurse practitioner (NP) regarding his difficulty sleeping. The NP did not write any orders. Staff to encourage him to remain in common areas and stay up longer to promote sleep. - 5/17/16 At 10:30 p.m. staff went to check on R254 and found him lying on the floor beside his bed. - 5/18/16 at 5:15 a.m. R254 was sitting at the nurses' station and requested his urinal. Staff went to his room to get it and returned to find R254 lying on the floor in the hallway. - 5/20/16 R254 was observed on the floor of his room beside his bed. A facility Event Report dated 5/20/16 indicated the fall occurred at 1:04 a.m. - 5/20/16 IDT note: R254's wife reported that prior to admit he had days and nights mixed up. Staff to encourage him to stay up much of the day. Video monitor placed in his room along with a landing mat. - 5/20/16 R254 was sent to the hospital due to left hip fracture. He re-admitted to the facility on 5/23/16. - 5/24/16 Progress note indicated R254 was to be moved closer to the nurses' station.	F 323		

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F 323	Continued From page 32 - 5/28/16 R254 restless at the beginning of the shift and attempting to crawl out of bed. - 6/30/16 R254 attempted to self transfer from his wheel chair and fell. A facility Event Report dated 6/30/16 indicated the fall occurred at 4:05 p.m. - 7/1/16 IDT note: R254 was reminded not to transfer without staff assistance. "Interventions previously placed still appropriate." - 7/5/16 Staff was called to R254's room, He was on the floor with his brief partially removed. A facility Event Report dated 7/5/16 indicated the fall occurred at 4:15 p.m. A review of a Physician Order Report indicated R254's medications had been adjusted as follows: On 7/5/16, Effexor (an antidepressant medication used to treat major depression, anxiety and panic disorder) 100 mg (milligrams) by mouth twice daily, increased from 75 mg twice daily and Seroquel (an antipsychotic medication) 25 mg by mouth daily as needed. On 7/6/16, Seroquel 25 mg by mouth to be given twice daily. - 7/7/16 At 10:45 p.m. staff was called to the floor after R254 was found on the floor next to his bed. A facility Event Report indicated the fall occurred on 7/6/16. -7/7/16 IDT note: Following a fall, R254's bed was switched to a low bed, care plan being followed at time of fall. -7/10/16 Staff observed R254 with his right knee on the floor next to his bed. A facility Event	F 323		

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F 323	Continued From page 33 Report indicated the fall occurred on 7/9/16, at 11:00 p.m. - 7/13/16 Staff was alerted by housekeeper that R254 was on the floor. He was lying on his right side approximately two feet from his bed and had removed his clothing and his brief. A facility Event Report dated 7/13/16 indicated the fall occurred at 9:15 a.m. - 7/14/16 While staff was bringing R254's meal to his room he was found lying on the floor next to his bed. A facility Event Report dated 7/14/16 indicated the fall occurred at 4:46 p.m. -7/15/16 Staff heard a noise coming from R254's room and found him lying on the floor beside his bed. A facility Event Report dated 7/15/16 indicated the fall occurred at 6:05 p.m. -7/15/16 Staff entered R254's room to assist his room mate and found him lying on the floor beside his bed. R254 had been incontinent of bowel. A facility Event Report dated 7/15/16 indicated the fall occurred at 9:04 p.m. -7/18/16 R254 "has had three falls today." Facility Event Reports dated 7/18/16 indicated R254 fell at 12:50 a.m., 9:30 a.m., and 1:45 p.m. - 7/18/16 Progress note indicated R254 enjoys sitting on the edge of his bed and appeared he had been sitting on the edge of his bed during two of his falls and slid off the bed. Spoke with NP who is reviewing medications. Goal is to remain free from injury. A review of a Physician Order Report indicated the following medication changes for R254:	F 323		

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7/18/16, Ativan 0.5 mg to be given twice daily for agitation. (Ativan is used to treat anxiety disorders.)

-7/18/16 R254 was again observed lying on the floor beside his bed. A facility Event Report dated 7/18/16 indicated this fall occurred at 8:26 p.m.

-7/20/16 IDT note: Continue to closely monitor R254.

A review of a Physician Order Report indicated the following new order for R254: Effexor, increased to 150 mg by mouth twice daily.

A Consultant Pharmacist Communication to Nursing dated 6/8/16 indicated R254 had an order for an antipsychotic and made the following recommendation: Side effect monitoring (including falls, orhtostaic blood presssures, sedation, anti-cholinergic)

A review of R254's Vital Signs Reports dated 5/3/16-7/22/16 indicated orthostatic blood pressures were completed only once on 5/12/16. The blood pressure was as follows: laying-125/61 mmHg, sitting 105/66 mmHg, standing 96/65 mmHg, indicating a significant drop when R254 stood.

During an observation on 7/21/16, at 2:28 p.m., R254 was lying in his bed. He had his eyes open and his right foot was resting on the floor next to his bed. His tray table was out of reach. The video monitor was present at the nurses station, however, no staff were at the desk in view of it.

During an interview on 7/20/16, at 7:33 p.m., The

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director of nursing (DON) stated falls are reviewed by the IDT (interdisciplinary team) daily unless they occur on a weekend, then they are discussed on the following Monday. She stated the group discusses what occurred and potential interventions. The DON stated if they feel they need more information they will go back and discuss the fall with staff. The DON stated R254 was admitted to the facility due to frequent falls at home and his wife's inability to to get him up off the floor. She further stated she felt he was depressed and was still adjusting to his placement in the facility.

During an interview on 7/21/16, at 6:05 a.m., nursing assistant (NA)-C stated R254 had fallen on her shift and stated he usually falls in between shifts. NA-C stated there were usually 2-3 staff on the unit but they are usually occupied doing something. She stated he has a bell to ring for assistance but does not always use it. She also stated R254 has a urinal that he uses but is occasionally incontinent on her shift. NA-C stated she felt R254 did not want to be in the facility and that it was contributing to his falls.

During an interview on 7/21/16, at 6:21 a.m., licensed practical nurse (LPN)-D stated R254 had fallen multiple times but not when she had been working. She stated they keep a camera at the desk and moved him close to the nurses station so staff could keep a closer eye on him.

During an interview on 7/21/16 at 10:56 a.m., registered nurse (RN)-A stated following R254's initial falls the facility implemented interventions that included a urinal at bed side and a request for the NP to review meds because his wife reported that his days and nights were mixed up

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while he was still at home. She stated the facility later added video monitoring and placed a landing mat next to his bed to reduce the risk for injury. RN-A stated after R254 fell and broke his hip his wife stated that he had been taking Seroquel at home at night and the facility got an order form the NP. RN-A further stated she felt the reason R254 had not fallen from 5/20/16 to 6/30/16 was due to pain and depression, and stated he had been refusing to get up. She stated she felt when he started feeling better was when he started falling again. RN-B stated she felt his most recent falls were related to agitation and mood and the goal was to prevent injury.

During an interview on 7/21/16, at 11:16 a.m., the DON stated she felt the majority of R254's falls were related to his adjustment. She stated he is incontinent of bladder and stated his toileting plan is the "typical", when he rises, prior to meals and before bed and he is offered a urinal at night. The DON stated no new assessments had been completed in an effort to identify a root cause of R254's falls.

A facility policy titled Cerenity Senior Care Falls Report and Assessment, dated 5/22/2012 indicated "it is the policy of Cerenity Senior Care in White Bear Lake to investigate all falls to ensure resident safety." The policy directed staff to provide appropriate follow up for every fall including measures taken to prevent reoccurrence.

Although the facility did implement interventions following many of R254's falls, the progress notes and the Event reports dated 5/3/16 through 7/20/16 lacked evidence that a comprehensive analysis of R254's falls had been completed.

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F 323	Continued From page 37 R254 was assessed to be incontinent of bladder and continent of bowel, however review of progress notes indicated he had been incontinent of bowel and bladder at the time of some of his falls and there was no evidence of a bowel and bladder assessment following the episodes. R254's care plan included medication changes per physician and NP (nurse practioner) orders, however, the consulting pharmacist made several recommendations regarding his medications which the facility did not act upon. Further, while many of the interventions included monitoring and injury prevention the facility progress notes lacked consistent evidence that measures were taken to reduce the risk of falls. As a result, R254 continued to sustain falls in the facility.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334		8/30/16

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F 334	Continued From page 38 representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or	F 334		

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F 334	Continued From page 39 the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pneumococcal vaccines were offered to 1 of 5 residents (R38) whose immunization records were reviewed. In addition, the facility failed to implement policies related to guidelines for Pneumococcal PCV (Pneumococcal Conjugate Vaccine)-13 as recommended by the Centers for Disease Control (CDC). Finding include: R38 was 91 years old, and was admitted to the facility on 11/16/14. Immunization records revealed the resident had received pneumococcal polysaccharide vaccination (PPV-23) on 8/29/06. There was no indication the PCV-13 had been offered to R38. On 7/22/16, at 2:16 p.m. the director of nursing (DON) provided the facility policy titled: Administration of Prevnar 13, Pneumovax 23. The DON stated the policy had not been implemented. The policy provided was a template from Benedictine Health System and the DON stated it needed to be individualized for this facility. On 7/22/16, at approximately 11:00 a.m., the medical director (MD) indicated he was not aware of the Pneumovax 23 and Prevnar 13 protocol for	F 334	F334 SS=D Influenza and Pneumococcal Immunizations The facility has policies and procedures in place to ensure that before offering the influenza immunization, each resident, or the president□s legal representative receives education regarding the benefits and potential side effects of the immunization; Each resident is offered the influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; The resident or the resident□s representative has the opportunity to refuse immunization; and The resident□s medical record includes documentation that indicates, at a minimum, the following: That the resident or resident□s legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility has policies and procedures in place to ensure that before offering the pneumococcal immunization, each	

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F 334	Continued From page 40 the facility.	F 334	resident, or the resident□s legal representative receives education regarding the benefits and potential side effects of the immunization; Each resident is offered the pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; The resident or the resident□s representative has the opportunity to refuse immunization; and The resident□s medical record includes documentation that indicates, at a minimum, the following: That the resident or resident□s legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindications or refusal. As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident□s legal representative refuses the second immunization. The Administration of Prevnar 13, Pneumovax 23 policy has been reviewed and implemented. Licensed staff have completed a review of all clients and have offered and administered, if appropriate, the pneumococcal polysaccharide vaccine (PPSV23) and the pneumococcal conjugate vaccine (PCV13), including	

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F 334	Continued From page 41	F 334	R38. All new admissions will have immunization records reviewed and will be offered the Pneumovax and/or Prevnar vaccine if applicable. Date, type of vaccine, or refusal will be documented on the clients face sheet in the electronic medical record. Education will be provided to all licensed nursing personnel, to ensure understanding of vaccination policy and administration of vaccinations. Licensed staff meeting is set up for August 25, 2016. New nursing staff will receive education regarding vaccination policy at new employee orientation. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month and reevaluate at Quality Council. DON or designee will review vaccination policy with medical director. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis.	
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353		8/30/16

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F 353	Continued From page 42 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services to ensure resident needs were met in timely manner. This had the potential to affect all 123 residents which included residents (R54, R144, R193, R248) in the facility. Findings include: Sufficient staffing triggered from resident complaints of lack of staff to assist with cares, answer call lights and provide basic needs, such as water and toileting. Residents had complained that incontinence episodes had occurred because assistance did not occur timely. The facility counted on volunteers to provide water containers to residents every day, when volunteers were not available, nursing was supposed to pass water containers, however the facility lacked a consistent way to notify nursing when they should pass water. Four long term care (LTC) units were being combined into two units for the purposes of providing nurse	F 353	F353 SS=F Sufficient 24-HR Nursing Staff per Care Plans The facility has policy and procedures in place to support sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychological well-being of each resident, as determined by resident assessments and individual plans of care. The facility provides services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with the resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Facility procedure called Serving Drinking Water was reviewed and updated. Facility Policy Answering the Call Light and	

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F 353	Continued From page 43 coverage, with the assistance of trained medication aides (TMAs) and nursing assistant (NAs). R54 was cognitively intact, had minimal depression, required a wheelchair when outside of her room, and was independent with cares. On 7/19/16, at 11:45 a.m. R54 stated she did not understand why she could not have a container of water in her room, as she had at her former nursing home. Anytime she wanted water she had to go out to the nursing station and ask, all they gave her was a small plastic glass of water, and sometimes it was just too much bother to go ask for a glass of water. R54 had a physician order to encourage fluids with medication pass. R54 further stated, one day she had requested medication for a headache and had to wait over 1 hour for the medication. R144 had moderate cognitive impairment, but did not have delirium or behaviors. R144 required extensive assist of two staff for transfers and toilet use, and was only able to stabilize with staff assistance when moving from seated to standing position, surface-to-surface transfers and on and off the toilet. On 7/21/16, at 4:18 p.m. R144 stated "a few days ago, there was only one aide here, I asked to go to the bathroom at 4:00, but I had to wait until 8:00 p.m. when I went to bed, to get changed. Many times the aides say there is only one for this wing and one for the next wing, so we have to be patient because they have many people. "A lot of staff are doing double shifts, no-one wants to work that hard and that's why they leave." R193 was cognitively intact, had minimal depression, and required extensive assistance of	F 353	Staffing Policy have been reviewed and deemed appropriate. Water will be passed by facility staff each shift following the procedure outlined. R54 has a water pitcher at her bedside for drinking. She has been encouraged to call or ask staff for more water if needed. Res was encouraged to use call light when calling for PRN Medications and if staff turns the call light off and does not return in approximately 10 minutes she should put the call light back on for assistance. R144 has been encouraged to use the call light when needing assistance. If staff turns the call light off, need has not been met and does not return in 5-10 minutes, resident was encouraged to turn the call light on again for assistance. R193 has been encouraged to use the call light when needing assistance. If staff turns the call light off and does not return in 5-10 minutes, resident and wife were encouraged to turn the call light back on for further assistance. R248 was asked their preferences on bathing and the schedule and care plan have been updated to reflect this information obtained. Extended wait time for answering call lights was reviewed for all residents in the facility. Facility call light system had been having issues with recording properly since June 6th, phantom lights were occurring and all batteries were replaced in all call light boxes to be sure the battery was not the issue. DON had been addressing the issues routinely with the company. On 7/14/16 a hard reset was completed by Advances Wireless and their staff	

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F 353	Continued From page 44 one staff for bed mobility, transfers, toileting, and dressing. On 7/22/16, at 12:30 p.m., R193's wife complained of lack of staff and stated they had to wait one hour for staff to assist her husband; further stated staff say they do not have enough help. R248 was cognitively intact, required extensive assistance of one person for bed mobility, transfers, and toilet use. When interviewed in stage 1, R248 stated they need more help, she would like to have more than one shower a week, but one was all they allow, do not have enough people [to help]. A review of the facility incident reporting for six months revealed: 1. 47 bruises of unknown origin 2. One elopement 3. 130 falls 4. 40 skin lacerations 5. Four medication errors A review of Extended Wait Time reports for the random days selected to review staffing revealed the following: On 5/1/16: 9 call lights were on for 30-45 minutes, five call lights were on for 46 minutes to one hour; one call light was on for one to two hours. On 5/27/16: 13 call lights were on for 30-45 minutes, eight call lights were on for 46 minutes to one hour, seven call lights were on for two to three hours, and four call lights were on for more than three hours. On 7/1/16: Two call lights were on for 30-45	F 353	reported the system was up and running. All batteries were again replaced in all call light boxes while the survey was in process to be sure batteries were not the issues again. Paper call light audit forms were implemented in June 2016 due to the inconsistencies with the call light system. Paper call light audit form has been updated to reflect resident room number, call light time on and off, and if resident need had been met. Call light reports will be run on a weekly basis by the DON and passed on to the unit managers for staff education and compliance with answering call lights within 5 minutes. Facility staffing schedules and assignments has been reviewed by the DON and staffing coordinators. Education for all nursing staff has been scheduled as follows: Licensed Staff on August 25, 2016 and Non- Licensed nursing staff on August 24, 2016. Education will include the following: Review of Serving Drinking Water procedure and process for this, call light answering expectation for staff within 5 minutes as well as to turn the call light off when the need has been met. Review of updated paper call light audit form. DON will also review the staffing ratios, per patient day and how those numbers come to be based on case mix, census and acuity. Preferences for frequency of bathing will be reviewed by activity staff on admission and annually and will be relayed to the unit manager. New staff will be made aware of these items at new employee orientation.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 45 minutes, one call light was on for 46 minutes to one hour, four call lights were on for one to two hours, one call light was on for two to three hours, and one call light was on for more than three hours. On 7/21/16: two call lights were on for 30-45 minutes, two call lights were on for 46 minutes to one hour, four call lights were on for one to two hours, two call lights were on for two to three hours, and six call lights were on for more than three hours. However, the administrator stated (during staffing interview at 10:40 on 7/22/16) call lights were expected to be answered within five minutes. A review of call light Audits revealed: Evergreen Trail a.m. shift on 4/1/16, check marks indicated call lights were answered within five minutes and all call lights were left within reach of the resident (the audit tool did not identify room number or resident, did not provide on and off times of call lights) Oak Crest a.m. shift on 4/4/16, hand written note indicated extended wait time in room 2231, resident had been assisted, but staff member forgot to turn off the light (The audit tool did not provide on and off times of call lights). Transtitional care Unit (TCU) 1 a.m. shift on 4/7/16, indicated room 108 call light was answered within five minutes, and call light was left within reach (the audit tool did not provide on and off times of call lights). Evergreen Trail a.m. shift on 6/29/16, call light was answered within five minutes (did not identify resident or room number, did not provide on and	F 353	DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month and reevaluate at Quality Council. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis.	

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off times of call lights); "call light was not left within reach of resident" clip on call light was replaced (the audit tool did not identify resident).

TCU 2 a.m. shift on 7/6/16, hand written note indicated room 204 waited eight minutes, and staff was educated on the facility five minute expectation.

Cedar Terrace a.m. shift on 7/7/16, call light answered 11 minutes, nine minutes, nine minutes (was in room at five minutes, but did not shut the call light off), two minutes, two minutes, 19 minutes, five minutes, and two minutes. A hand written note stated very mixed call light times. Depended on if NA's were in other rooms or not. All call lights were within reach. A hand written note indicated: "reviewed spoke with staff and educated."

Cedar court a.m. shift, on 7/7/16, the call light audit had room numbers and times listed, but it did not explain what the numbers meant, or how long call lights were on.
TCU 1 1st floor a.m. shift on 7/8/16, call light was answered within 2 minutes 10 seconds.

The call light audits failed to identify rooms and how long the call light had been on. The call light audit tool was yes/no boxes and lacked adequate information to determine compliance with answering call lights in the facilities established five minute expectation and did not indicate if the resident need had been met.

On 7/22/16, at 10:30 a.m. the staffer and assistant director of nursing (ADON) were interviewed and stated that LTC staff all have block schedules and work 8-hour shifts, and TCU

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nurses worked 12 hour shifts. There was a sign up book to pick up extra shifts, and that staffing was based on HPPD (hour per patient day) and acuity, but staffer and ADON were not able to say what the HPPD number was. Staffing on each unit was discussed, the facility had been combining units and rather than staffing a nurse on each unit. The facility census was:

Cedar Terrace 23 residents

Cypress Court 18 residents

Oak Crest 14 resident's Oak Crossing 16 residents

Oak Crossing 16 residents

Evergreen 16 residents

TCU 1st floor 18 residents

TCU 2nd floor 17 residents

Oak Crest and Oak Crossing were being combined into one unit. The new staffing pattern was one nurse and one TMA and a minimum of three NAs for days and evenings. I nurse and 2-3 NA on nights (depending on the other units having enough NA coverage).

Cypress Court had one nurse and two NA on days and evenings; Cedar Terrace had one nurse and three NA on days and evenings, but shared one nurse and two NA on the night shift with Cedar Terrace.

Evergreen (locked memory care) had one nurse two NA's on days and evenings and one nurse

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and one NA on night shift.

Agency nursing (supplemental nursing services agency) were routinely used 2-3 times per week, (counted both NA and nurse) for 24 hours (48 hours per 2-week pay period).

The facility did flex down when census decreased. The ADON stated that occasionally the facility would add another person if needed for acuity, but mostly needed to do better team work.

On 7/19/16, at 1:19 p.m. the staff development nurse stated orientation was run every other Wednesday and Thursday, occasionally people were started in between orientations.

A review of random days with staffer and ADON revealed:
On 4/25/16: Day 1 registered nurse (RN), 1 TMA on oak crossing and cedar terrace (there was an NA that called off, we have a TMA also an NA TMA was pulled to NA position, nurse pulled TMA (pick up) shift.

Evening four nurses plus one on light duty. One TMA evergreen trail, help cypress court with afternoon cares. Cypress Court help with Oak Crest and Oak Crossing, because they looked a little short (not as many staff, as we would usually have there, for whatever reason).

Night fully staffed with three nurses and five aides no call in's [for all of LTC]
The TCU had 3 NA on day shift, but 4.5 NA on evening shift.

On 5/1/16: Day Sunday, Charge of building five nurses, NA called in sick, moved one NA from

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upstairs to downstairs, Pick up shift to cover upstairs. One NA had to leave at 2: instead of three, covered for her for last hour, "worked together."

Evening four nurses, 1 TMA on Evergreen Terrace, nurse on Oak Crossing to help cover Evergreen Terrace, aides fully staffed, (2nd TMA available)

Night, nurse call in, 3 nurses, NA called in, 2 aides on Cedar Terrace/Cypress Court three on Oak Crest/Oak Crossing and 1 on Evergreen Terrace, and six NAs.
LTC day shift had 10 NAs, while evenings had 13 NAs.

On 5/27 and 5/28/16, LTC lack staffing sheets for evening and night shift. Lacked staff postings for TCU, and for LTC night and evening shifts.

On 7/1/16: Day 3 nurses, TMA cover Evergreen Terrace, TMA assist on Oak Crest/Oak Crossing, 12 NAs in building

Evening three nurses, 2-10:30 4th nurse comes at 6:00 p.m. on Friday, TMA to cover until 6:00, 1 TMA, an aide/TMA/ she did first med pass on Oak Crossing to help with shortage so nurse could help cover Cypress Court. Seven NAs 2:30-11. One that stayed from days until 8 p.m. to help cover. (One NAR training), one NA on light duty, helps where needed. Started on Evergreen Terrace.

Night three nurses 10:00-6:30, nurse that started at 6:00 pm and worked until 6:30 am, (to help cover aides) three aides. A total of seven on shift all had to pitch in and be done. The staff posting

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indicated TCU evenings was short one nurse, and LTC was short two NAs on day shift.

The staffer stated "it is fair to say occasionally have to go short." Further stated, "But if had to do that all the time I wouldn't be doing my job." Staffer also stated if staff on light duty, may be weight restriction, list of restrictions in charge book and were assigned appropriate task. Staffer further stated, "We try to keep on regular schedule, just not doing regular duties. I try not to count light duty in regular shift number, I try to keep them extra."

On 7/22/16, at 2:19 p.m. RN-D stated that residents received water with continental breakfast, meals and snack; volunteers come in daily and pass green or pink water mugs between 11:00 and 1:00. The volunteers were supposed to check in with the nurse every day to ensure people could have water, RN-D was not aware that not everyone was receiving water containers on both units. RN-D stated he had been the weekend support person, and was here entire shifts on the weekends, interacting with residents and families.

On 7/22/16, at 3:40 p.m. The director of nursing (DON) and ADON stated LTC was downsized, stopped admissions to long-term care in an effort to keep staffing ratio. When family members expressed concerns, they were educated on the downsizing of long-term care. For families who questioned the staffing we had 1:1 conversations. DON stated the facility expectation for staff answering call lights was 5 minutes and under. Efforts had been made to keep TCU beds open for admits, had to manage TCU to 30 beds [40] for staffing purposes. DON stated the facility had

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been using pool [agency] nursing. Working with people on shifts, flexing hours split overtime shifts for each nurse picks up 4 hours [12 hour shift], and staff would pick up shifts, and work double shifts. When asked about the summary of call light logs, the DON stated curious of that data and was working with the vendor on phantom call lights. DON further stated, staffing was always a challenge, occasionally the facility was short, had been working very hard on hiring new staff. The majority of reasons staff gave for leaving was wage, more acute settings, and job openings at hospital but the nurses [who left] do stay on call here.

The ADON stated 34 RN's and licesned practical nurse (LPNs) were hired in last three months, and 109 nursing assistants had been hired (Probably longer than 3-month period). The DON was asked to supply the documentation that she had been working with the vendor on call light issues, the documentation included: issues with not receiving reports of call lights, and outages of call lights. The emails also emphasized the importance of the call lights being properly connected to the wall boxes. DON further stated, "The facility had lower staffing ratio's then surrounding facilities, but [facility] had reached a crisis point and staff had to deal with the new situation. We do whatever we are in control of to boost morale, we started a manager on duty (MOD) in house every weekend for four hour stint and that had supported staff."

The Human resources director was asked if exit interviews were done, and on 7/22/16, provided a report with the reasons staff had reported to the facility for leaving such as hospital job, hospital pays more, want to try something else, and

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F 353	Continued From page 52 sounded like a good opportunityand was the person dream job. The open positions included LTC NA 5 evening positions totaling 3 FTE (Full Time Equivalent) =80 hours per week, and 1 night shift position for .4 FTE (32 hours per 2 week). LTC RN/LPN no job openings TCU NA night shift 1.0 FTE (80 hours/2 week pay period) TCU RN/LPN days/evenings 1 position totaling .6 FTE (48 hours per 2-week pay period) TCU evenings and night shift 2 positions totaling 1.35 FTE (108 hours in a 2-week pay period) (hired 2 RN's start in orientation the 27th). 2016 turnover rate: NA 35% and RN/LPN 7% Staff interviews On 7/20/16, at 7:30 p.m., NA-D stated when asked about staffing "to be honest with you we are short staffed here and sometimes I have residents with call lights going at the same time and is up to the other aide to help me. It can be a challenge to get all the work done." On 7/20/16, at 7:33 p.m., NA-E stated she felt the unit would use more hands on deck. NA-E further stated she felt she had not had a situation a resident was not safe however thought there was not enough staff to do more things with the residents as the staff had to get things done and had to stay on task. On 7/20/16, at 7:41 p.m. RN-F stated with	F 353		

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sufficient staffing "depends on patient acuity. When the acuity is, high it does not matter the staffing is the same and this always has an effect."

On 7/20/16, at 7:47 p.m. NA-F "Am going to be honest and have to say we are short staffed and this is not all the time but more times than you know it. I have been in situations when I felt the safety of the residents was not being followed and I have gone home and had my meltdowns. I was actually going to have a meeting with management about the staffing issue. When I started working here it was okay, now you have way too many things going at you, and there is just not enough staff to get it done. I feel the residents are here for us to help them and if we are not able to help then we have problems."

On 7/22/16, at 8:09 a.m. LPN-A stated, "We are always short staffed here. We do our best. They hire and train people but cannot keep them. You see all the aides here now; most of them are college students and in a month or so will not be here. There used to be two nurse one for each of the units and now we have one nurse for both and a TMA [trained medication aide] and the nurse has one cart and also has to do the treatments for both units which includes insulins which can all be a challenge to do timely."

Staffing Policy (2001 med-Pass, Inc., revised April 2007). Indicated: "Our facility provides adequate staffing to meet needed care and services for our resident population."

Answering the Call Light Policy (2001 med-Pass, Inc., revised October 2010), indicated: The purpose of this procedure is to respond to the

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F 353	Continued From page 54 resident's requests and needs. 4. Be sure the call light is plugged in at all times. 5. When the resident is in bed, or confined to a chair be sure the call light is within easy reach of the resident. 7. Report all defective call lights to the nurse supervisor promptly 8. Answer the resident's call as soon as possible.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356		8/30/16

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F 356	Continued From page 55 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to retain the staff postings for 18 months as required. Findings include: Staff postings (Daily Nurse Staffing) were requested for three month period from 4/21/16, through 7/21/16. The Long Term Care (LTC) staff posting was recorded separate from the transitional unit (TCU) staff posting, but were both displayed and observed at the reception desk at the main door. The TCU Daily Nurse Staffing sheets provided by the facility were blank for the dates of 5/4/16 and 5/10/16. The facility was unable to provide the Daily Nurse Staffing sheets for 5/14/16 through 5/24/16, for LTC or TCU. For the period 5/27/16 through 5/31/16, the TCU Daily Nurse Staffing sheets were blank. The same period LTC Daily Nurse Staffing sheets, night and evening shift sections were blank. The Daily Nurse Staffing sheets were not provided for LTC or TCU for the period of 6/5/16 through 6/30/16. The Daily Nurse Staffing sheets were not provided for LTC or TCU for the period of 7/2/16	F 356	F356 SS=C Posted Nurse Staffing Information The facility has policies and procedures in place to ensure the daily posting of the following: facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses (as defined under state law), certified nurse aides, and resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: clear and readable format, in a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. The policy Posting Direct Care Daily Staffing Numbers was reviewed and remains appropriate. Director of Nursing has adjusted the staff postings form to reflect how long the facility is to maintain the daily nurse staffing data for. This new	

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F 356	Continued From page 56 through 7/21/16. During interview on 7/22/16, at 2:30 p.m. the administrative assistant stated that those were all the Daily Nurse Staffing sheets she could provide. The bottom of each staff posting directed the staff to "post daily for each shift the number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. This information should be displayed in a place where residents and the general public can easily view it." However, there was no direction for staff as to how long the staff were to maintain the posted information.	F 356	form will be used going forward for daily posting of direct care staffing numbers. The forms will be maintained in one location for 18 months. Licensed staff and staffing coordinators will be educated on August 25th on the Posting Direct Care Daily Staffing Numbers policy, the procedure for completing this form and that they are maintained for 18 months. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month and reevaluate at Quality Council. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on- going monitoring/auditing after analysis.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and maintain	F 371	F 371 SS=F Food Procedure, Store/Prepare/Serve □ Sanitary	8/30/16

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F 371	Continued From page 57 safe dishwashing temperatures, and the facility failed to maintain sanitary conditions for cooking and/or griddle top pans in 5 of 7 kitchenettes and the main kitchen to prevent the possibility for food borne illness. This had the potential to affect 121 of 123 residents who were served food and/or fluids out of all 5 kitchenettes and the main kitchen. Findings include: Main kitchen On 7/19/2016 7:10 a.m. a stainless steel fan approximately four feet tall was observed at the entrance door to the kitchen facing and blowing air towards the front prep area. The fan grates were observed to have fluffy gray black matter build-up. When asked how often the fan was cleaned the director of culinary services (CSD) stated the cooks cleaned the fans in the kitchen and maintenance cleaned the fan mounted on the wall. -At 7:30 a.m. the black fans attached to the condenser in the walking cooler were observed with black/gray fluffy matter. CSD verified fans were not clean and stated they were a challenge to be clean and maintenance had just replaced one of the missing grate. -At 7:34 a.m. in the back cart room the grates of a fan mounted on the wall were observed with a thick film of black, gray fluffy matter build-up. The fan was blowing air to the prep tablems below where CSD stated dietary staff used to do preping. CSD verified stated all fans mounted to the wall were cleaned by the maintenance department. Kitchenettes During the facility tour on 7/19/16, at 7:45 a.m.	F 371	The facility has policies in place to assure food is procured from sources approved or considered; satisfactory by Federal, State and local authorities. Store, prepare, distribute and serve food under sanitary conditions. Culinary management reviewed the Dishwashing Procedure, updated it and has deemed it appropriate. On 7/19/16 Ecolab came in and put a sanitizer liquid on the machine and supervisors were taught how to test the dishwashing machine. On 7/20/16 the Director of Culinary Services taught all cooks how to test the temperature and sanitizer on the dish washing machine. Only the cooks will be testing the machine, once in the am and once in the pm. ON 8/12/16 the dish machine was fixed. Will keep the sanitizer on until the in-service on 8/24/16. All fans have been added to the weekly maintenance cleaning schedule and are in clean working order. All fans were cleaned by maintenance on 7/19/16, fans were re-evaluated on 7/20/16 and were cleaned if needed. Fans are not blowing on food prep areas. All griddles have been replaced and are in clean working order. Mandatory in-service for all culinary personal, to ensure understanding of procedures, monitoring, documentation of dish washer temperatures and when to report abnormal temperatures will be held on August 24, 2016 given by Ecolab. Staff will also be educated on the use of the griddle and how to clean them at this in-service. Staff will sign off on procedure and understanding. New culinary	

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F 371	Continued From page 58 the following was observed and confirmed by the Culinary Services Directors (CSD) Cedar Terrace kitchenette griddle top pan approximately 16 inches long by 8 inches wide was observed on the flat top stove and had heavy buildup of a black substance on the edges of the griddle. Transitional Care unit (TCU-1) kitchenette griddle was observed with black baked on buildup on the edges and the cooking surface of the griddle. Dietary aide (DA)-D verified stated she had been off. TCU-2 kitchenette griddle was observed with black baked on substance on the edges and on the cooking surface was all dark. GardenView kitchenette griddle was observed with black baked substance on the edges and the bottom cooking surface was black. CSD verified stated there is no excuse. During the tour DA-E verified stated she was the full time dietary aide in the kitchenette and had not worked the previous day. Oak Crest kitchenette griddle was was noted to have a black buildup substance on the cooking surface of the griddle. During kitchen tour on 7/21/16, at 7:10 a.m. CSD stated the facility used a high temperature, one compartment dishwasher machine. During a quick review of the wash and rinse temperature log it was revealed the July 2016, dishwashing temperature log had multiple temperatures below 180 degrees Fahrenheit (F) for the rinse cycle. CDS verified the low readings and at the time	F 371	personnel will be educated on Dishwasher Temperatures and monitoring during new employee orientation and sill sign off understanding of this. Mandatory in-service for all culinary personal, to ensure understanding of procedures for use of fans, cleanliness of fans and when to report and not use a fan will be held on August 24, 2016. Staff will sign off on procedure and understanding. New culinary personnel will be educated on Dishwasher Temperatures and monitoring during new employee orientation and sill sign off understanding of this. To ensure compliance the culinary management staff will conduct audits on dishwasher temps 3 audits per week per shift x 2 weeks, then one audit per week per shift x 4 weeks then one audit per shift per month x 2 months. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring / auditing after analysis.	

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F 371	Continued From page 59 surveyor requested to return to the kitchen to observe the dishwasher after the brunch meal. On 7/19/2016 11:35 a.m. during a follow up kitchen tour DA-B was ran nine loads of dishes through the dishwasher. The digital temperature gauge on the outside of the dishwasher read: #1. 160 F wash, rinse temp noted to drop from 174 F to 158 F. #2. 162 F wash and rinse 182 F. #3. 164 F wash and rinse 168 F. #4. 160 F wash and rinse 168 F. #5. 160 F wash and rinse 168 F. #6. 160 F wash and rinse 160 F. #7. 160 F wash and rinse 168 F. #8. 160 F wash and rinse 172 F. #9. 160 F wash and rinse 158 F. DA-B verified and stated, "that's not good." Surveyor requested to see the supervisor. On 7/19/16, at 11:44 a.m. culinary supervisor (CS)-A stated he thought he may have to reset the booster heater as sometimes it malfunctioned. CS-A then ran the diswasher again and the digital temperature gauge on the outside of the dishwasher read: #10. 160 F wash and rinse 158 F. #11. 160 F wash and rinse 192 F. #12. 160 F wash and rinse 168 F. -At 11:49 a.m. the CS-A was observed go to the other side where the booster was located came back to the dirty side of the dishwasher stated he thought the booster needed the reset however did not need it. -At 11:52 a.m. CS-A stated the dishwasher was not holding temps and rinse temperatures were dropping down to 160's Fwhen the manufacture plate directed "Hobart Vulcan 160 (971 C) 180 F (82 C)."	F 371		

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F 371	Continued From page 60 Review of the Dish Machine Temperature Log sheets from May 2016 - 7/19/16, identified the dishwasher wash/rinse temperatures were checked twice a day. The wash temperatures were missing or below 160 degrees F in May, 18 of 60 opportunities; June, 19 of 60 opportunities and in July, 3 of 37 opportunities. The rinse temperatures were missing or below 180 degrees F in May, 25 of 62 opportunities; in June 19 of 60 opportunities and in July 21 of 37 opportunities. On 7/19/16, at 11:56 a.m CS-A stated he checked the dishwasher logs at the end of the month and during the month when able to. He indicated he was not aware the rinse temperatures were low and expected the staff to have reported each time they identified the rinse temperatures were low than the recommended temperature as indicated on the plate by the manufacturer. On 7/19/16, at 12:41 p.m. cook (C)-A stated usually the cook in the morning checked and recorded the wash and rinse temperatures after letting a few dishes through. C-A reviewed the July 2016, Dish Machine Temperature Log verified the rinse temps had been recorded low then the recommended manufacturer plate on the diswasher temperature. C-A stated she would expect the staff to report to the cook, supervisor, and maintenance for the issue to be addressed accordingly. On 7/19/16, at 12:47 p.m. CS-B approached stated he had put a call out to the Ecolab staff and had put a sign up to alert staff not to use the dishwasher and staff were aware until further notice.	F 371		

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F 371	Continued From page 61 On 7/20/16, at 12:16 p.m. Ecolab staff and CSD approached. Ecolab staff stated he had been at the facility the previous day 7/19/16, and had at the time put the chemical to be used as the sanitizer together with the heat. He indicated he had ran through multiple racks of and the temperature was ranging between 160 F to 164 F with the thermometer he used. He also indicated he would always check the "The ware temperature" during his monthly visit to the facility and thought was all normal standards. Staff indicated he did not think the dishwasher had a problem and indicated the recommended temperature was 171 F. When asked if he thought the the staff was supposed to follow the manufacturer plate for the temperaturers recommended, Ecolab staff stated he would leave it for the staff to use as guide. He further stated he had ordered a new temperature gauge and would in-service the staff again. On 7/20/16, at 2:11 p.m. during a follow-up tour to the kitchen a fan was observed on the floor in the front prep/cook area that was still dirty and blowing to the prep area. In addition, the fan mounted to the wall in the back cart/prep room was observed on and air blowing towards the prep area where a cart with uncovered pies was standing. On 7/20/16, at 2:45 p.m. CSD stated she followed the Ecolab staff word for the rinse temperatures and that was what she would tell her staff. CSD acknowledged the Hobart manufacturer recommended temperature on the plate was 180 F. On 7/20/16, at 2:48 p.m. via telephone with the survey team indicated the final rinse was not	F 371		

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F 371	Continued From page 62 important and thought the wash cycle was more important as the dishes were in for a few minutes before hitting the rinse cycle. He stated he went by the ware temperature and if it was 160-164 it was okay than checking the temperature gauge on the dishwasher. On 7/20/16, at 4:11 p.m. the environmental services director (ESD) stated he thought the fans had been cleaned on 7/19/16, after the concern was brought to the facility attention. He further acknowledged the fans had not been cleaned for a couple of weeks as his department had one of the staff out. At 4:15 p.m. ESD verified the fans were dirty. He un-plugged the fan in the cart/prep room that was on. On 7/22/16, at 9:07 a.m. CSD stated she acknowledged the concerns surveyor had identified and was working on a plan to make sure the facility was in compliance. On 7/21/16, at 3:20 p.m. Ecolab staff, his supervisor and CSD approached surveyor team stated currently the dishwasher was running a chemical sanitation. They indicated they had been running chemical since Tuesday when concern was brought to the fcility attention. They stated another Ecolab staff had been in the same day and found gas valve was not igniting enough to get the temperature. Ecolab supervisor stated when the issue has been fixed the dishwasher was going to go back to high temp sanitization. Ecolab staff stated "From here forward it's not going to be an issue. Shame on me, I didn't stop to make sure the temperature was getting to 180." Ecolab supervisor stated his staff should have catch that, as he needed to check the gauge. When asked if staff should have reported	F 371		

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F 371	Continued From page 63 the low temperatures less than 180 F CSD stated "We will do inservice on it, I have a lot of new staff." The facility undated Dishwashing Procedures directed "The temperature of the water shall be maintained at 140 [degree] F for the washing cycle (or according to the manufacturers instructions) and at 180 [degree] F for the rising and sanitizing cycle (180 [degree F], 160 F at the rack and dish/utensils surfaces). The flow pressure shall be maintained between 15 and 25 pounds per square inch (PSI)..."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that pharmacy recommendations for 3 of 5 residents (R7, R35, R143) whose medication regimens were reviewed, had been reported to the attending physician and/or that the reports had been acted upon.	F 428	F 428 SS = D Drug Regimen Review, Report Irregular, Act On The facility has policies and procedures in place to ensure each resident□s drug regimen is reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the	8/30/16

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F 428	Continued From page 64 Findings include: R7 had 6 of 10 months from 8/11/15 through 5/13/16, of pharmacy drug irregularities and/or recommendations not acted upon. R7 was admitted to the facility on 7/1/14, per the Face Sheet. Diagnoses included schizophrenia, bipolar disorder, depression and obsessive compulsive personality disorder. Record review of the consultant pharmacist (CP) monthly report for 9/10/15, 12/3/15 and 2/9/16, revealed R7 had been prescribed Effexor XR (antidepressant) for depression, Zyprexa and Seroquel (antipsychotics) for schizophrenia. The consultant pharmacist reported drug irregularities with the medication regime and the record review lacked evidence of response to the consultant pharmacist recommendations. Record review of the CP monthly report for 3/10/16, revealed R7 was on an antacid with no uniform and standard documentation on use of the range (e.g., 5-10 milliliter (mL) and required side effect monitoring associated with antipsychotic drug therapy. The CP reported drug irregularities with the medication regime and the record review lacked evidence of response to the consultant pharmacist recommendations. Record review of the CP monthly report for 4/13/16, revealed R7 had duplicate eye drop therapies and orthostatic blood pressure and target behaviors missing. The CP reported drug irregularities with the medication regime and the record review lacked evidence of response to the CP recommendations.	F 428	attending physician, and the director of nursing, and these reports must be acted upon. Gradual Dose Reduction Policy was reviewed and deemed appropriate. Procedure for how to complete the Pharmacy Consultant Recommendations was created. Policy for Psychotropic Medication Monitoring was review and deemed appropriate. R7, R35 and R143 have had the Pharmacy Consultants recommendations followed up on at this time. All residents that have had pharmacy consultant reports completed in the last 60 days have been reviewed and discussed with the MD or NP for follow up. All residents in the facility that have a psychoactive medication ordered have been reviewed and have target behaviors monitoring and side effect monitoring in place. All residents that have an antipsychotic medication ordered also have a monthly orthostatic blood pressure ordered. All residents taking medication to assist with sleep will have hours of sleep logged each night in the MAR/TAR. All residents taking an antacid medication will have the proper doses in place. Consultant Pharmacist will resend the recommendations given at the following visit noting **Second Request** and pass this on to the DON in her reports. Consultant Pharmacist will record recommendations in the electronic medical record. Consultant Pharmacist will address the number of second requests as well as the number of requests sent and number of requests	

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F 428	Continued From page 65 Record review of the CP monthly report for 5/13/16, revealed R7 had been prescribed ammonium lactate cream, vitamin B-12, ferrous sulfate and Prevacid daily and again addressed that R7 was on an antacid with no uniform and standard documentation on use of the range (e.g., 5-10 mL). The CP reported drug irregularities with the medication regime and the record review lacked evidence of response to the CP recommendations. During interview on 7/22/16, at 1:42 p.m. registered nurse (RN)-D stated he could not find the recommendations from the CP and they were not scanned in the medical record. RN-D stated he did not recall ever seeing any recommendations for R7 since he took over in the middle or end of February further stating "I know we need a better system, I would say they were not followed up on, I can't find them." R35 had four of 10 months from 8/11/15 through 5/13/16, of pharmacy drug irregularities and/or recommendations not acted upon. R35 was admitted to the facility on 6/23/11. Diagnoses included dementia, Alzheimer's and history of sepsis obtained from the undated Resident Face Sheet. Record review of the CP monthly report for 11/11/15, R35 had been prescribed Haldol (antipsychotic) and lorazepam (antianxiety) as needed. The CP reported drug irregularities with the medication regime and the record review lacked evidence of response to the CP recommendations.	F 428	received back in her quarterly report given at Quality Council. Any resident taking a psychotropic medication has this reflected in their care plan. New residents are assessed on admission for the use of Psychotropic Medication and its monitoring. Education will be provided for all licensed nursing personnel, to ensure understanding of the Psychotropic Medication Policy, Gradual Dose Reduction Policy and the procedure for completing the Pharmacy Consultant Recommendations. Licensed staff meeting is set up for August 25, 2016. New nursing staff will receive education regarding the Psychotropic Medication Monitoring, Gradual Dose Reductions and procedure for completing Pharmacy Consultant Recommendations during new employee orientation. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 3 month and reevaluate at Quality Council. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis.	

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Record review of the CP monthly report for 1/12/16, R35 had been prescribed Haldol (antipsychotic) and lorazepam (antianxiety) as needed. CP reported drug irregularities with the medication regime and the record review again lacked evidence of response to the CP recommendations.

Record review of the CP monthly report for 3/10/16, R35 had been prescribed Haldol (antipsychotic) and lorazepam (antianxiety) as needed. The CP reported drug irregularities with the medication regime and the record review again lacked evidence of response to the CP recommendations.

Record review of the consultant pharmacist monthly report for 5/13/16, R35 had been prescribed Haldol (antipsychotic) and lorazepam (antianxiety) as needed and duplicate bowel suppositories. The CP reported drug irregularities with the medication regime and the record review lacked evidence of response to the CP's same recommendations since 11/11/15, six months ago.

During interview on 7/22/16, at 2:57 p.m. RN-D stated he could not find the pharmacist recommendations for R35, but the pharmacist printed them out today for R7 and R35. RN-D stated "I know we need a better system, they were not followed up on."

During interview on 7/22/16, at 3:32 p.m. director of nursing (DON) stated the monthly pharmacist recommendations are put in a binder on the units, but "we couldn't find them so my guess is they were not addressed." DON further stated that the pharmacist reviews that did not have

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recommendations are not part of the record, "we will be changing that process and the pharmacist will be charting in matrix."

Review of the undated facility Monthly Medication Review policy indicated the consultant pharmacist (CP) "performs a comprehensive medication regimen review (MRR) at least monthly for each resident. Resident-specific irregularities identified during the MRR and/or clinically significant risks resulting from or associated with medications are documented in the resident's medical record and reported to the Director of Nursing (DON), and/or prescriber as appropriate. The CP will prepare and deliver an individual report to the DON for each irregularity identified as well as documenting date of review and nature of irregularity in the resident's clinical record. If no irregularities are detected at the time of the MRR [medication regimen review], the consultant pharmacist documents this finding in the resident's medical record, and signs and dates such documentation."

R143's quarterly minimum data set (MDS) dated 6/20/15, indicated he was severely cognitively impaired and displayed mild depression. A review of a Resident Face Sheet identified diagnoses that included pain, dementia without behavioral disturbance, constipation, dementia with behaviors, anxiety disorder and insomnia. R143's care plan dated 7/16/16, identified alterations in mood and use of anti-psychotic medication and directed staff to monitor behaviors, dose of medication/dose reduction and side effects and to keep physician updated.

A review of a Cerenity Care Center - White Bear Lake Physician Order Report dated 6/22/16

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through 7/22/16, indicated R143 was receiving the following medications: Depakote 125 milligrams (mg) twice daily, Trazadone 25 mg daily at 4:00 p.m. and Ativan 0.5 mg every two hours for restlessness, anxiety or sleep. A review of the MAR indicated Ativan had not been used however, there was no evidence of anxiety, restlessness or sleep monitoring on the Medication Administration Record (MAR).

A review of a pharmacy consultant medication recommendations revealed the following:

- 8/12/15 indicated use of Depakote 125 mg twice daily and Trazadone 25 mg at bedtime and indicated a gradual dose reduction (GDR) had been declined by the physician on 5/2014. The pharmacy consultant requested a GDR and a clinical rationale if medication could not be reduced.

- 9/11/15 indicated resident had been receiving an iron supplement and recommended the following labs: hemoglobin and iron panel every six months or discontinuation of iron supplement if no longer necessary.

- 11/12/15 indicated use of Depakote 125 mg twice daily and Trazadone 25 mg at bedtime and indicated a gradual dose reduction (GDR) had been declined by the physician on 5/2014. The pharmacy consultant requested a GDR and a clinical rationale if medication could not be reduced.

- 2/12/16 indicated use of Depakote 125 mg twice daily and Trazadone 25 mg at bedtime and indicated a gradual dose reduction (GDR) had been declined by the physician on 5/2014. The

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	245300	A. BUILDING _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1900 WEBBER STREET WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 69	F 428		

pharmacy consultant requested a GDR and a clinical rationale if medication could not be reduced and indicated resident had been receiving an iron supplement and recommended the following labs: hemoglobin and iron panel every six months or discontinuation of iron supplement if no longer necessary.

- 5/17/16 indicated R143 had and order for Ativan 0.5 mg every two hours as needed for restlessness, anxiety and sleep. Please make sure restlessness and anxiety are clearly defined by core behaviors on the MAR, sleep monitoring and side effect monitoring. Further, indicated use of Depakote 125 mg twice daily and Trazadone 25 mg at bedtime and indicated GDR had been declined by the physician on 5/2014. The CP requested a GDR and a clinical rationale if medication could not be reduced and indicated resident had been receiving an iron supplement and recommended the following labs: hemoglobin and iron panel every six months or discontinuation of iron supplement if no longer necessary.

A Consultant Pharmacist Communication to Physician completed by the nurse practitioner, dated 6/20/16, indicated the NP addressed the recommendations for Trazadone and Depakote and Iron, eight months after the pharmacist made the initial recommendation.

During an interview on 7/22/16, at 10:03 a.m., registered nurse (RN)-A stated the consulting pharmacist comes to the facility every 30 days and reviews each patient. She stated if recommendations are made they get put in a folder the physician or NP to review. RN-A stated she was unsure if any of the recommendations

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	245300	A. BUILDING _____ B. WING _____	07/22/2016

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F 428	Continued From page 70 had been followed up on. During an interview on 7/22/16, at 10:56 a.m., the director of nursing (DON) stated the pharmacy consultant sends her recommendations via e-mail. She stated she prints them out and gives to the clinical manager for follow up. She stated some of the physicians take them home and do not follow up on them. She stated the follow up "didn't happen." During an interview on 7/22/16, at 3:05 p.m., the consultant pharmacist (CP) stated she writes recommendations and if they are not followed up on she will readdress in 60 days. She stated she has brought the lack of follow up to the facility quality assurance team. During a subsequent interview on 7/22/16, at 3:43 p.m., the DON stated "we don't have a good process for follow up." A facility policy titled General Dose Reduction, dated 6/15, indicated the pharmacist will do a monthly medication review and recommend a GDR based on clinical data and pharmacy guidelines. Recommendations will be reviewed by the physician/NP. If the physician chooses to decline a GDR, documentation should be provided to support the decision.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/20/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Sate Fire Marshal Division on July 20, 2016. At the time of this survey, Cerenity Care Center White Bear Lake was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2016

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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	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/20/2016**

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

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	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/20/2016**

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K 000	Continued From page 2 notification. The facility has a capacity of 138 beds and had a census of 126 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 126 residents. Findings include: On a facility tour between the hours of 10:00 AM	K 050	1) Next drill will be a minimum of two hours separation from previous drills. 2) The maintenance director will review 3rd shift drill times for proper separation. 3)QA will review all fire drills times to ensure compliance.	8/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/20/2016**

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K 050	Continued From page 3 and 02:00 PM on July 20, 2016, observation revealed that the fire drills for the third shift were conducted at 0510, 0505, 0507 and 0530. These times are not varied in accordance with NFPA 101 (LSC 2000) 19.7.1.2 This deficient practice was confirmed by the Director of Maintenance at the time of inspection.	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **02 - 2013 ADDITION** B. WING _____	**07/20/2016**

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