#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: KDU3

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AG	ENCY	F	acility ID: 00354	
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245365  2.STATE VENDOR OR MEDICAID NO.     (L2) 723816900		3. NAME AND ADD (L3) CERENITY ( (L4) 200 EARL ST (L5) SAINT PAUL	CARE CENTER FREET		(L6)	55106	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHI (L9)		7. PROVIDER/SUF	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint	
6. DATE OF SURVEY 08/19/2016  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)	
	<b>0</b> (L18) <b>0</b> (L17)	B. Not in Com	nce With quirements		2. Tech	nical Personnel our RN y RN (Rural SNF)	Following Requirements:  6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room  (L12)	tor	
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  90  (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY M 1861 (e) (1) or		(L15)		
16. STATE SURVEY AGENCY REMARKS (IF A  17. SURVEYOR SIGNATURE	PPLICABLE S	BHOW LTC CANCELL Date:	ATION DATE):		18. STATE SURV	VEY AGENCY API	PROVAL	Date:	
Susanne Reuss, Unit	Superv	isor	08/19/2016	(L19)	Kate JohnsTon, Program Specialist 08/30/2016 (L20)				
PA	RT II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Participate     2. Facility is not Eligible	(L21)		IPLIANCE WITH C	IVIL	<ul> <li>21. 1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ul>				
OF PARTICIPATION 11/01/1986	TC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)					ARY  eet Health/Safety eet Agreement	
(1.27)	ALTERNATIVAL Suspension B. Rescind Sus		(L44) (L45)		03-Risk of Involur 04-Other Reason f		OTHER 07-Provider 00-Active	Status Change	
28. TERMINATION DATE: (L.	29	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARKS				
31. RO RECEIPT OF CMS-1539 (L.		. DETERMINATION ( 08/09/2016	OF APPROVAL DAT	(L33)		7/13/2016 Co.	VAL		



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245365 August 30, 2016

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

Dear Ms. Juday Barnett:

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

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

Effective August 9, 2016 the above facility is certified for or recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Cerenity Care Center - Marian August 30, 2016 Page 2

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

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 30, 2016

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

RE: Project Number S5365025

Dear Ms. Juday Barnett:

On July 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 30, 2016. 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 August 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 25, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 30, 2016, effective August 9, 2016 and therefore remedies outlined in our letter to you dated July 15, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Cerenity Care Center - Marian August 30, 2016 Page 2

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

#### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245365 <sub>Y1</sub>	B. Wing	Y2	8/19/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENITY CARE CENTER - MAR	RIAN	200 EARL STREET		
		SAINT PAUL, MN 55106		

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

ITEN	VI	DATE	ITEM	ı	DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. #	F0278 483.20(g) - (j)	Correction	ID Prefix F0279 483.20(	(d), 483,20(k)(1)	orrection ompleted	ID Prefix Reg. #	F0282 483.20(k)(3)(ii)		Correction Completed
LSC		08/04/2016	LSC	08.	3/04/2016	LSC		0	08/04/2016
ID Prefix	F0309 483.25	Correction	ID Prefix F0311 483.25(	(a)(2)	orrection	ID Prefix	F0371 483.35(i)		Correction
Reg. # LSC		08/04/2016	Reg. #		ompleted 8/04/2016	Reg. # LSC			08/04/2016
ID Prefix		Correction	ID Prefix	Co	orrection	ID Prefix		(	Correction
Reg. #		Completed	Reg. #	Co	ompleted	Reg.#		(	Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix	Co	orrection	ID Prefix			Correction
Reg. #		Completed	Reg. #	Co	ompleted	Reg.#		(	Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix	Co	orrection	ID Prefix		(	Correction
Reg. #		Completed	Reg. #	Co	ompleted	Reg. #			Completed
LSC			LSC			LSC			
REVIEWEI		REVIEWED BY (INITIALS) SR/KJ	DATE 08/30/2016	ł		1986		DATE 08/19/	/2016
REVIEWEI	D ВҮ 🔲	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/30/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES NO						□ NO	

#### POST-CERTIFICATION REVISIT REPORT

				<b></b>	•	<i>,</i>	• • • • •	• • • • • • • • • • • • • • • • • • • •				
	R / SUPPLI CATION NU			TRUCTION MAIN BUILI	טואוכ ט	1					DATE O	F REVISIT
245365	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	VIDEI	Y1 B. Wing	WAIN BOIL	DING 0	ı				YZ	8/25/20	16 <sub>Y3</sub>
NAME OF	FACILITY						STREET	ADDRESS, CIT	Y, STATE, ZIF	CODE	•	
CERENI	TY CARE	CENT	ER - MARIAN				200 EAR	L STREET				
							SAINT P	AUL, MN 55106				
program, corrected provision	to show th I and the d	nose of ate si nd the	by a qualified State surveyor deficiencies previously repo uch corrective action was a e identification prefix code p	rted on the ( ccomplished	CMS-25 Each	667, Staten deficiency	ment of Do	eficiencies and e fully identifie	Plan of Cor d using eithe	rection, that hav er the regulation	e been or LSC	
ITE	М		DATE	ITEM				DATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #	NFPA 101		Completed	Reg. #	NFPA 1	01		Completed	Reg. #	NFPA 101		Completed
LSC	K0018		08/09/2016	LSC	K0025			07/25/2016	LSC	K0062		08/09/2016
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			
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			
REVIEWE STATE AC			REVIEWED BY (INITIALS) TL/KJ	DATE 08/30/2	2016	SIGNATUR	RE OF SUI		35482		DATE 08/2	5/2016
REVIEWE CMS RO	D BY		REVIEWED BY (INITIALS)	DATE		TITLE					DATE	
	FOLLOWUP TO SURVEY COMPLETED ON 6/29/2016				CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES NO							s 🗆 no



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted August 30, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number F5365025

Dear Ms. Juday Barnett:

The above facility was surveyed on August 19, 2016 through August 19, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Cerenity Care Center - Marian August 30, 2016 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

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

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Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted August 30, 2016

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Cerenity Care Center - Marian August 30, 2016 Page 2

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Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

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(s)

cc: Original - Facility

Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINSTRATION

Provider/Supplier Number

FORM APPROVED OMB No. 0938-0391

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26648, Baltimore, ND 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Name

245365	CERENITY CARE CTR MARIAN	
Type of Survey (select all that ap	A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanction/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life safety Code L Chow	
D	A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA) D Other Survey	

SURVEY TEAM AND WORKLOAD DATA
Please enter the workload information for each surveyor. Use the surveyor's information number.

Arrived (B) Departed (C) (D) 12am-8am (C) (E) (D) (D) (D) (D) (D) (D) (D) (D) (D) (D									
1, 16022	Surveyor Id Number	Date Arrived	Date Departed	Preparation Hours	Hours 12am-8am	Hours 8am-6pm	Hours 6pm-12am	Hours	Preparation Hours
3. 4. 5. 6. 7. 8. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9.	Team Leader 1. 16022			0.25	0.00	0.00	0.00	0.00	0.25
4. 5. 6. 7. 8. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9.	2.								
5. 6. 7. 8. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9.	3.								
6.	4.								
7. 8. 9.	5.								
9.	6.								
9.	7.								
	8.								
10.	9.								
	10.								

Total Supervisory Review Hours	0.2
Potal Clerical/Data Entry Hours	3.2
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	

FORM HCFA-670 (12-91)

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number		Provider/Supplier Na	ame						
245365		CERENITY CARE CENTER - MARIAN							
Type of Survey (select all that apply)	Α	Complaint Investigation	Е	Initial Certification	I	Recertification			
I - I - I - I - I	В	Dumping Investigation	F	Inspection of Care	J	Sanctions/Hearing			
I   D   H	C	Federal Monitoring	G	Validation	K	State License			
<u> </u>	D	Follow-up Visit	Η	Life Safety Code	L	CHOW			
	M	Other							
Extent of Survey (select all that apply)		coutine/Standard Survey (all pro							
		extended Survey (HHA or Long	Term	Care Facility)					
A	C F	artial Extended Survey (HHA)							
	D (	Other Survey							

#### SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 37010	08/25/2016	08/25/2016	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.25

Total RO Clerical/Data Entry Hours.... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

FORM CMS-670 (12-91) EventID: KDU322 Facility ID: 00354 Page

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: KDU3

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PAI	KI I - IO BE COM	IPLE LED BY	THE STATE	E SURVEY AGENCY	Fa	icility ID: 00354
MEDICARE/MEDICAID PROVIDER N     (L1) 245365	NO.	3. NAME AND AD (L3) CERENITY				4. TYPE OF ACTION:	_2 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO.		(L4) 200 EARL S	TREET			3. Termination	4. CHOW
(L2) <b>723816900</b>		(L5) SAINT PAU	L, MN		(L6) <b>55106</b>	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SU	PPLIER CATEGOI	RY	<u>02</u> (L7)	7. On-Site Visit  8. Full Survey After Con	9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Full Survey After Coll	прияни
6. DATE OF SURVEY 06/30	<b>0/2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	EICCAL VEAR ENDING I	NATE: (I 25)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING I	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	S:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of Th	ne Following Requirements:	_
To (b):		Program Re			2. Technical Personnel	6. Scope of Service	es Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director	or
12.Total Facility Beds	<b>90</b> (L18)	1. A	Acceptable POC		4. 7-Day RN (Rural SNF	8. Patient Room Si	ize
13. Total Certified Beds	90 (L17)	X B Not in Com	npliance with Progra	am	5. Life Safety Code	9. Beds/Room	
13. Total Certified Beds	20 (217)		and/or Applied Wai		* Code: <b>B*</b>	(L12)	
14. LTC CERTIFIED BED BREAKDOWN	I	1			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
90	.,				1001 (1) (1) 11 1001 (1) (1)	. ,	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLI	E SHOW LTC CANCELI	LATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	PPROVAL	Date:
Mary Cape	s, HFE NE	II	07/25/2016	(L19)	Kate JohnsTon, P	Program Specialis	08/02/2016 (L20)
	PART II - TO	O BE COMPLETE	D BY HCFA R	REGIONAL	OFFICE OR SINGLE STA	TE AGENCY	(220)
19. DETERMINATION OF ELIGIBILITY	Y		MPLIANCE WITH	CIVIL	21. 1. Statement of Finan		
1. Facility is Eligible to Pa	rticipate	RIGI	HTS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	I Interest Disclosure Stmt (HCFA- :	-1513)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT	24. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L	30)
OF PARTICIPATION	BEGINNIN	G DATE	ENDING DA	ТЕ	VOLUNTARY 0	00 INVOLUNTA	ARY
11/01/1986					01-Merger, Closure	05-Fail to Med	et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursem	ent 06-Fail to Med	et Agreement
25. LTC EXTENSION DATE:		IVE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
20. ETC ETTE (OTC.) ETTE.		on of Admissions:			04-Other Reason for Withdrawal	07-Provider S	tatus Change
			(L44)			00-Active	
(L27)	B. Rescind S	uspension Date:					
			(L45)				
28. TERMINATION DATE:		29. INTERMEDIARY/C	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
21. BO DECEMBE OF ONC 1520		22 DETERMINATION	OE A DEPOSITATION	ATE			
31. RO RECEIPT OF CMS-1539		32. DETERMINATION	of Approval Da		Posted 08/04/2016 Co.		
	(I.32)			(L33)	DETERMINIATION ADDRO	TVAI	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 15, 2016

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

RE: Project Number S5365025

Dear Ms. Juday Barnett:

On June 30, 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:

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Susanne.reuss@state.mn.us

Phone: (651) 201-3793 Fax: (651) 215-9697

#### **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 9, 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 9, 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 September 30, 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 December 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### **INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

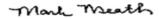
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

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, 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

PRINTED: 08/02/2016 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		X3) DATE SURVEY COMPLETED
		245365	B. WING			06/30/2016
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F 278 SS=D	as your allegation of Department's accept enrolled in ePOC, yo at the bottom of the f form. Your electronic be used as verification.  Upon receipt of an accept enrolled in ePOC, you at the bottom of the f form. Your electronic be used as verification.  Upon receipt of an accept enrolled in expectation in the second property of the second prop	cceptable electronic POC, an a facility may be conducted to tial compliance with the attained in accordance with attained in accordance with SSMENT DINATION/CERTIFIED at accurately reflect the staccurately reflect the ust conduct or coordinate the appropriate in professionals.  Sust sign and certify that the eted.  Completes a portion of the properties a material and resident assessment is ey penalty of not more than essment; or an individual who y causes another individual	F 2'	78		8/4/16
LABORATORY	-	Ind false statement in a SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE

Electronically Signed 07/25/2016

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		l' /	(X3) DATE SURVEY COMPLETED		
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F 278	penalty of not more to assessment.  Clinical disagreement material and false statement	is subject to a civil money han \$5,000 for each at does not constitute a atement.  It is not met as evidenced and document review, the de an accurate initial conditions for 1 of 3 residents	F2	C Pa ha Su Co a of ar	erenity Senior Care - Marian of Sa aul's Credible Allegation of Complia as been prepared and timely submit abmission of this Credible Allegation applainace is not a legal admission deficiency exists or that the Statem the Deficiencies were correctly situated is also not to be construed as an almission against interest of the Fact. Administrator or any employees,	ance itted. on of n that nent ed,		
	pressure ulcers. The dated 5/30/16, reveal pressure ulcers and goal of comfort. The to nurse notes, hosp administration record and hospital docume.  A Skin Risk Assessm completed on 5/23/1 R62 was not assessment of pressure ulcers. No it assessment of pressure years note, date was open areas to R	care area assessment, led R62 had multiple stage 2 was on hospice care with a care area assessments refer ice notes, electronic medical I (EMAR), physician notes intation.  The assessment indicated ed for the presence of reason for lack of ure ulcers was provided.  The assessment indicated ed 5/23/16, revealed there 62's left ankle, left small to the foot but no staging, type of		ag m: Al pr Cr nc of fa cc th su Cr fe Cr te St pa As	gents or other individuals who draft ay be discussed in thie Credible legation of Compliance. In addition eparation and submission of this redicble Allegation of Compliance of contsitute an admission or agree any kind by Facility of the truth of cts alleged or the correctness of an inclusions set forth in this allegation is survey agency. Accordingly, we also be survey agency. Accordingly, we also be survey agency and the Allegation of compliance solely because state and deral law mandate submission of a redible Allegation of Compliance with attement of Deficincies as a conditional according to the Allegation of Compliance and Medical according to the Allegation of Compliance and Medical according to the Allegation of Compliance of Credible Allegation of Credib	does ment any ny n by are ithin ne on to lical on of		

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	24 hours of Admissio R62 had a left ankle unspecified wounds or right foot.	dent Care Plan Initiate within n, dated 5/24/16, indicated wound at a stage 3 and on right heel, and 2nd toe risit, dated 5/27/16, revealed		within this time frame should considered or construed as a with the allegations of non-conduction admission by the Facility. R62 is an 85 year old male with diagnosis of PMH,CAD,PVD, disease,CKD stage III and H	greement ompliance or rith a Alzheimer's		
	R62 had "open woun digit" and "left open a vascular disease" and foot between fourth a Left ankle with dressi today."	d to left foot the 4th and 5th area on ankle", "peripheral d "unstageable area on left and fifth digits scabbing over. ing over did not visualize		admitted on 5/23/16 with thre ulcers on lower extremities. F Hospice Care, requires total a with mobility and is receiving His weekly skin assessments completed with improvement without signs and symptoms	ee pressure Resident is on assistance wound care. s are noted and of infection.		
	5/30/16 revealed "no	ment addendum, dated n-healing pressure ulcers of kle" and "new open area on left foot"		The resident has a current sk assessment with Braden scal on 7/7/16.Staff member respondence completion of the skin assess Braden scale completed on 5	le completed onsible for sment with		
	reported he determin stage 2 ulcers by rev did not observe the w	n.m. the MDS nurse (RN)-B ed the presence of four iewing documentation and younds. RN-B was unable to a stating R62 had four stage		received education on proper of this assessment tool.  Admission process has been include skin audit of boney pr within three hours of admissionurse. The admission calend revised to include completion	revised to rominences on by a ar has been		
	reported the admission not be accurate.	p.m. the director of nursing on MDS assessment may		assessment with Braden scal alteration present, nurse is to Clinical Manager and Wound Nurses will complete a skin ri	le: if skin o notify the Nurse. isk		
	directed staff "A Skin Form/Braden Scale is or return from a hosp Annually with the MD Change, d. With onse Weekly skin assessm weeks after admissio	s initiated: a. On admission, ital stay, b. Quarterly and PS, c. With Significant et of a new pressure ulcer, e. nents for a total of four		assessment with Braden scal times four weeks on all new a there is a pressure ulcer pres wound round team will assur assessment and documentat includes the healing progress location and adequacy of the treatment plan. Recommendat treatment changes or plan of	admissions. If sent, our re weekly ion that sion, size, current ations for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	I' '	(X3) DATE SURVEY COMPLETED	
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F 278	the resident's initial slidentify any pre-existi integrity." and "If a prelicensed nurse is notificensed in Matrix informed and will initial.	kin inspection/audit and ng signs of altered skin essure ulcer is observed, a fied and a Skin Event Report a. A designated nurse is then ated A Pressure g Form for each pressure	F 2	revisions will be documented an to the attending physician. Each resident with current press has been reviewed by the clinical manager to assure accurate assure and documentation is present. When a resident is admitted to the admission calendar is initiate includes a skin risk assessment Braden scale. The calendar has revised to include a check every for completion of all required assessments by the assigned not licensed nurses will be educated process including revision of addicalendar, completion of assessments and the admissions will be completed assessments with Brade for new admissions will be completed assessment with Brade for new admissions will be completed assessment with Brade for new admissions will assure completion accuracy of skin risk assessment with Braden scale of admitted residents with pressure during wound rounds.  This plan of correction is integrated our quality improvement process audit results and analysis will be presented to our quality improve team and approved by the Admited The quality improvement team with plement needed changes and determine the need for ongoing monitoring/ auditing after analys Director of Nursing is responsible plan of correction.	sure ulcers al sessment our facility ed which with s been 24 hours urse. All d on the mission nents and ion. etion of len scale oleted times four on all e ulcers ted into s. The ement nistrator. vill l		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279 F 279 SS=D	to develop, review comprehensive pla	k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's		279 279			8/4/16
	medical, nursing, a needs that are ider assessment.  The care plan mus to be furnished to a highest practicable psychosocial well-l §483.25; and any side to the resident §483.10, including under §483.10(b)(4).  This REQUIREME by:	NT is not met as evidenced					
	interview, the facility dialysis access site resident (R19) revibring include:  During observation 10:39 a.m. R19 way dialysis access site area on her upper,	tion, document review, and ty did not accurately identify the e in the plan of care for 1 of 1 ewed for dialysis.  I in R19's room on 6/30/16, at as asked the location of her e. The resident pointed to an left chest area that was assing and stated that the			Cerenity Senior Care - Marian of Sai Paul's Credible Allegation of Complia has been prepared and timely submit Submission of this Credible Allegation Complainace is not a legal admission a deficiency exists or that the Statem of the Deficiencies were correctly site and is also not to be construed as an admission against interest of the Fac its Administrator or any employees, agents or other individuals who draft may be discussed in thie Credible	nce tted. n of n that ent ed,	

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site for dia surveyor h shunt on h that no lor dialysis.  Record redated 3/1/ undated D Shunt: Rig port. The June 2016 check the the fistula monitoring Flowsheet access site [three time explanation The currer contained receives h approache bruit/thrill a shunt site, infection, with the access [blood prewhen interegistered of the dialy that he was identificati During internursing as	ort under the lysis. The lysis. The er right for er right for ger function wiew reveal 16, that real ialysis Cartht Arm," where the contained bruit/thrill a site every set the port site contained the er for redness daily] [side en of the local transport of the local transport of the port site and observith no direct set is site. One essure] on Friewed on nurse (RN visis accesses a not sure, esident's des reviewed on or location of location of location of sistant (NA sistant).	ne dressing was her access resident then showed the earm and stated that the earm was an old access site ins and it is not used for her led a physician's order, ad, "Dialysis: M-W-F" An e Plan read, "Location of ith no mention of the chest Administration History for entries that directed staff to and monitor for bleeding at shift, with no entry for ite. The Medication an entry that read, "Monitor is bleeding or swelling tide;", with no further cation of the access site. In for R19, dated 5/31/16, that read, "Resident is 3 times weekly" The problem included checking ite, managing bleeding at ving the access site for ection as to the location of approach read, "No B/P RIGHT arm."  16/30/16, at 11:40 a.m.  1)-A was asked the location is site for R19 and he replied but that information would italysis binder. The dialysis and did not contain it in of the dialysis chest port.  16/30/16 at 11:51 a.m., it is a more interesting that she is site and replied that she is site and replied that she	F	2279	Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance doe not contsitute an admission or agreemed of any kind by Facility of the truth of an facts alleged or the correctness of any conclusions set forth in this allegation of the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance with ten(10) calendar days of receipt of the Statement of Deficincies as a condition particopate in the Medicare and Medica Assistance programs. The submission the Credible Allegation of Compliance within this time frame should in no way considered or construed as agreement with the allegations of non-compliance admission by the Facility.  R19 plan of care has been revised to include resident's specific dialysis accesite in use, monitoring orders, nursing assistant care guide and nurses communication sheet. A dialysis check for admissions has been revised to include specific dialysis site, placing an order to monitor specific site for bruit/th bleeding, redness or swelling and other treatment orders necessary.  Currently there are no other residents receiving dialysis. The revised checklis will be used for all future residents on dialysis. The nurses will be educated of the revisions to the policy by August 4, 2016.  This plan of correction is integrated into the revision of correction is integrated into the revisio	ent y  by  in to al of be or ss list rill, rill,	

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	ROVIDER OR SUPPLIER	IAN		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET SAINT PAUL, MN 55106	
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F 279 F 282 SS=D	on her right arm. RN-A was interviewed p.m. and asked if the documentation of the and he replied that he documentation, but he has a left chest portowas cognitively able dialysis access site.  483.20(k)(3)(ii) SERV PERSONS/PER CANTON The services provided must be provided by	believed R19 had a shunt ad again on 6/30/16 at 2:18 are was any other adialysis access site for R19, are was not aware of any other are was now aware that R19 are was now aware that	F 27	our quality improvement process. The checklist will serve as our audit tool at the clinical managers will complete waudits on residents receiving dialysis four weeks and as deemed necessar quality committee. Analysis of the observations and facility compliance be presented to our quality improvement am and approved by the Administration The quality improvement team will implement needed changes and determine the need for ongoing monitoring/ auditing after analysis. The Director of Nursing is responsible for plan of correction.	eekly for y by will eent ator.
	care.  This REQUIREMEN' by: Based on observation review, the facility fair for restorative nursin of 1 residents (R41)  Findings include:  Review of R41's care revealed a problem "requiring assistance living] secondary to N	T is not met as evidenced on, interview, and document led to ensure the care plan g services was followed for 1 reviewed for ambulation. e plan, dated 12/11/2015, Mobility Deficit resident with ADLs [activities of daily NSTEMI [type of heart weakness" with a goal		Cerenity Senior Care - Marian of Sai Paul's Credible Allegation of Complia has been prepared and timely submit Submission of this Credible Allegation Complainace is not a legal admission a deficiency exists or that the Statem of the Deficiencies were correctly site and is also not to be construed as an admission against interest of the Facilits Administrator or any employees, agents or other individuals who draft may be discussed in thie Credible	nce ited. in of ithat ent ed, illity,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E SURVEY MPLETED
		245365	B. WING		0	6/30/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	· · · · · · · · · · · · · · · · · · ·	0/00/2010
				200 EARL STREET		
CERENITY	Y CARE CENTER - MAR	IAN		SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	Continued From pag	e 7	F 28	32		
F 282	"Resident will be able independently" and a required assistance, mobility, while encour independence as able Review of the Nursin undated, directed staresident AM [morning Walker, belt and followable." On 6/27/16 at 5:58 p supposed to be assist walking at least daily happening on a regular on 6/29/16 at 8:53 a (NA)-D, reported she walking program with a.m. NA-D reported she walking program with a.m. NA-D reported she walking program with a.m. NA-D reported she was not reported she thought on 6/29/16 at 10:55 manager, (RN)-A reput documentation indicated completed, it was now way to know if it was offered.  On 6/29/16 at 11:05 assistant, (NA)-E, represponsible for walking requires assistant, (NA)-E, represponsible for walking requires assistant.	e to ambulate/transfer in intervention "Provide stand-by to extensive, for raging as much e."  g Assistant Care Sheet, off "Offer to ambulate of and PM [afternoon]: we with WC [wheelchair]"  .m., R41 reported he was steed by nursing staff with the point of the poin	F 28	Allegation of Compliance. In preparation and submission Credicble Allegation of Comnot contsitute an admission of any kind by Facility of the facts alleged or the correctn conclusions set forth in this the survey agency. According submitting this Credible Alle Compliance solely because federal law mandate submisted Credible Allegation of Compliance for Deficincies as particopate in the Medicare Assistance programs. The statement of Deficincies as particopate in the Medicare Assistance programs. The state Credible Allegation of Compliance or construed as with the allegations of non-admission by the Facility. R41 was admitted on 11/15/diagnosis of MI, Atrial Fib. a and received therapy service 2/29/16 with documentation refusals during that timefrant of care has been revised to ambulation program with culindicating resident averaging up to 300 feet with good tolegoal is to walk twice a day. It assistant plan of care has beand nursing assistants have by restorative aide on reside ambulation program.	of this opliance does or agreement to truth of any less of any allegation by any may, we are gation of state and sion of a state and sion of ompliance do in no way be agreement compliance or with a land obesity less through of frequent me. The plan include an arrent results godaily walks learnce. The Nursing leen updated le been trained	
	assigned to be walke	ed by his floor nursing tive because he was an		Clinical Managers will review plans and documentation of on ambulation programs to accurate completion of the p	the residents assure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245365	B. WING _			06/	30/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDENITY	CARE CENTER - MARI	A N		20	00 EARL STREET		
CERENIII	CARE CENTER - MARI	AN		S	AINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page	e 8	F 2	282			
	NA-D walked with R4 recreation room and accompanied NA-D a wheelchair behind R4 experience shortness completed the entire wanted to be walking and skills up. R41 reptime walking the halls Review of Point of Camany times R41 walk discharge from physic March 2016, R41 was assistleast once on 10 days 2016, R41 was assistleast once on 4 days (6/1/16 to 6/30/16) R4 corridor at least once Review of Progress redated 2/29/16 to 6/30/16	s of breath but persisted and route. R41 reported he again to keep his abilities ported this was only his 7th with nursing staff.  The History revealed how are deach month following cal therapy on 2/29/16. In a sassisted to walk in corridor days out of 31 days. In April ted to walk in corridor at so out of 30 days. In May ted to walk in corridor at out of 31 days. In June 41 was assisted to walk in			The care plans are reviewed quarterly to the Clinical Manager per the RAI process and revised as needed. Upon discharge from physical therapy the therapists recommends restorative nursing ambulation programs as appropriate including program specifics for individual resident. Therapist also reviews the recommended plan with the Clinical Manager and Restorative Aide.  Clinical Manager will assure the nursing order is in the electronic health record was program specifics, create plan of care from the program specifics, create plan of care from the plan of care and provide training assistant plan of care and provide training as needed. Restorative Aide and Clinical Managers will assure program completing and goal success.  Audits will be completed on current residents with restorative ambulation programs weekly times four weeks by clinical manager or designee and then a deemed necessary based on results. The audit will include the care plan for appropriateness of the program and the goals, resident participation and completion of documentation.  Analysis of the observations and facility compliance will be presented to our quality improvement team and approve by the Administrator. The quality improvement team will implement need changes and determine the need for ongoing monitoring/ auditing after analysis. The Director of Nursing is	ss e al givith or ng al on as he	
F 309 SS=D	483.25 PROVIDE CA HIGHEST WELL BEI		F3	309	responsible for this plan of correction.		8/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245365	B. WING _		06	6/30/2016	
	ROVIDER OR SUPPLIER	ARIAN		STREET ADDRESS, CITY, STATE, ZIP CO 200 EARL STREET SAINT PAUL, MN 55106	· · · · · · · · · · · · · · · · · · ·		
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F 309	provide the neces or maintain the hig mental, and psych	st receive and the facility must sary care and services to attain ghest practicable physical, nosocial well-being, in he comprehensive assessment	F3	309			
	by: Based on observinterview, the facidialysis access siresident (R19) review of the facidialysis access siresident (R19) review of the facidialysis access sires and an her uppear covered with a drecatheter port undes site for dialysis. The form of the facility of the f	ation, document review, and lity did not accurately identify the te in the plan of care for 1 of 1 viewed for dialysis.  In in R19's room on 6/30/16, at as asked the location of her te. The resident pointed to an release that was easing and stated that the er the dressing was her access the resident then showed the forearm and stated that the forearm was an old access site ctions and it is not used for her with no mention of the chest ent Administration History for need entries that directed staff to cill and monitor for bleeding at early shift, with no entry for		Cerenity Senior Care - Mar Paul's Credible Allegation of has been prepared and time Submission of this Credible Complainace is not a legal and deficiency exists or that the of the Deficiencies were contained and is also not to be constructed admission against interest of its Administrator or any emplayents or other individuals of may be discussed in this Credible Allegation of Compliance. In preparation and submission Credicble Allegation of Commot contsitute an admission of any kind by Facility of the facts alleged or the correct conclusions set forth in this the survey agency. According submitting this Credible Allegation of Compliance solely because federal law mandate submist Credible Allegation of Compliance Solely because federal law mandate submist Credible Allegation of Compliance Solely because federal law mandate submist Credible Allegation of Compliance Solely because federal law mandate submist Credible Allegation of Compliance Solely because federal law mandate submist Credible Allegation of Compliance Solely because federal law mandate submist Credible Allegation of Compliance Solely because federal law mandate submist Credible Allegation of Compliance Solely because federal law mandate submist Credible Allegation of Compliance Solely because federal law mandate submist Credible Allegation of Compliance Solely because federal Deficiencies as	of Compliance ely submitted. Allegation of admission that he Statement rectly sited, hed as an of the Facility, holoyees, who draft or redible he addtion, ho of this hopliance does hor agreement he truth of any hess of any helegation by helegation of he state and heliance within hoceipt of the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(2) MULTIPLE CONSTRUCTION  . BUILDING		(X3) DATE SURVEY COMPLETED	
		245365	B. WING _		0	6/30/2016	
	ROVIDER OR SUPPLIER Y CARE CENTER - MARI	AN		STREET ADDRESS, CITY, STATE, ZIP ( 200 EARL STREET SAINT PAUL, MN 55106	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	access site for redne [three times daily] [sidexplanation of the local The current care plan contained a problem receives hemodialysi approaches for this pubruit/thrill at shunt site shunt site, and obserinfection, with no direction, with no direction pressure on February (RN of the dialysis access that he was not sure, be in the resident's dialysis access that he was reviewed identification or location or loca	te. The Medication an entry that read, "Monitor as bleeding or swelling tided," with no further cation of the access site. In for R19, dated 5/31/16, that read, "Resident as 3 times weekly" The problem included checking the access site for exterior as to the location of approach read, "No B/P RIGHT arm."  6/30/16, at 11:40 a.m., as asked the location as site for R19 and he replied but that information would italysis binder. The dialysis and did not contain on of the dialysis chest port. (3/30/16 at 11:51 a.m., as site and replied that she believed R19 had a shunt as site and relied that she believed R19 had a shunt as site and relied as a site and replied that she believed R19 had a shunt as site and relied as a site and relied that she believed R19 had a shunt as a site and relied as a site and relied that she believed R19 had a shunt as a site and relied that a site and relied that she believed R19 had a shunt as a site and relied that a she as a site and relied that a she are relied to the site and relied that a she are relied to the site and relied that a she are relied to the site and relied that a she are relied to the site and relied that a she are relied to the site and relied that a she are relied to the site and relied that a she are relied to the site and relied that a she are relied to the site and relied that a she are relied to the site and relied that a she are relied to the site and	F3	Assistance programs. The the Credible Allegation of within this time frame shou considered or construed a with the allegations of non admission by the Facility.  R19 plan of care has been include resident's specific site in use, monitoring order assistant care guide and note communication sheet. A differ admissions has been resided include specific dialysis site order to monitor specific sibleeding, redness or swell treatment orders necessar Currently there are no other receiving dialysis. The reviwill be used for all future redialysis. The nurses will be the revisions to the policy 2016.  This plan of correction is in our quality improvement prochecklist will serve as our the clinical managers will caudits on residents receiving observations and facility of be presented to our quality team and approved by the The quality improvement to implement needed changed determine the need for one monitoring/ auditing after a Director of Nursing is responding of correction.	Compliance ald in no way be a sagreement compliance or a revised to dialysis access ers, nursing areses ialysis checklist evised to e, placing an atte for bruit/thrill, ing and other ry. Er residents ised checklist esidents on e educated on by August 4, antegrated into rocess. The audit tool and complete weekly ng dialysis for dinecessary by sof the compliance will ry improvement Administrator. eam will es and going analysis. The		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245365	B. WING _			06/30/2016		
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CEDENITY	CARE CENTER - MARI	IANI		2	00 EARL STREET			
CERENIII	CARE CENTER - WAR	AN		S	SAINT PAUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 311 SS=D	IMPROVE/MAINTAIN		F:	311			8/4/16	
	services to maintain	e appropriate treatment and or improve his or her abilities h (a)(1) of this section.						
	by:	Γ is not met as evidenced on, interview, and document			Cerenity Senior Care - Marian of Saint			
	review, the facility fai	led to provide restorative			Paul's Credible Allegation of Compliand	е		
	_	naintain or improve walking			has been prepared and timely submitte			
		large from physical therapy,			Submission of this Credible Allegation of			
	TOT TOT TRESIDENTS (F	R41) reviewed for walking.			Complainace is not a legal admission to a deficiency exists or that the Statemer			
	Findings include:				of the Deficiencies were correctly sited,			
					and is also not to be construed as an			
		ecent minimum data set			admission against interest of the Facilit	y,		
	·-	essment, dated 5/20/16,			its Administrator or any employees,			
		gnitively intact. The MDS ed one person physical			agents or other individuals who draft or			
	assistance to walk or				may be discussed in thie Credible Allegation of Compliance. In addtion,			
		uld not be determined as			preparation and submission of this			
	R41 walked only onc				Credicble Allegation of Compliance doe	26		
	assessment reference				not contsitute an admission or agreeme			
		- position (i. stayle).			of any kind by Facility of the truth of any			
	On 6/27/16 at 5:58 p.	.m., R41 reported he was			facts alleged or the correctness of any	-		
		sted with walking at least			conclusions set forth in this allegation b	у		
	daily, but recalled be	ing assisted with walking			the survey agency. Accordingy, we are			
	only six times in the I	ast three months.			submitting this Credible Allegation of Compliance solely because state and			
	On 6/29/16 at 8:53 a	.m., R41's nursing assistant,			federal law mandate submission of a			
		was not currently assisting			Credible Allegation of Compliance withi	n		
	R41 with a walking p	· · · · · · · · · · · · · · · · · · ·			ten(10) calendar days of receipt of the			
					Statement of Deficincies as a condition			
		.m., R41's floor nurse,			particopate in the Medicare and Medica			
		1 did a walking program with			Assistance programs. The submission	of		
		ng assistant. LPN-A reported ng assistant documented it			the Credible Allegation of Compliance within this time frame should in no way	be		
		-			1		1 I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
		245365	B. WING			6/30/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	0/00/2010	
				200 EARL STREET			
CERENITY	CARE CENTER - MAR	AN		SAINT PAUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 311	Continued From pag	e 12	F 3	11			
	and she was not resp completion of daily w	ponsible for monitoring the ralking for R41.		considered or construed as a with the allegations of non- con admission by the Facility.  R41 was admitted on 11/15/1	ompliance or		
	manager, (RN)-A, re walking program "by had not complained to program. RN-A report directions to offer R4 assistance on the nut after that, the nursing responsible for the was reported if the point of indicated the walking not completed. There was offered and reful was no monitoring of walking occurred or in the walk	alking program. RN-A of care documentation was not completed, it was was no way to know if it sed or not offered. There distance walked, just if not. RN-A reported the ssistant was responsible for		diagnosis of MI, Atrial Fib. and and received therapy services 2/29/16 with documentation or refusals during that timeframe of care has been revised to in ambulation program with currindicating resident averaging up to 300 feet with good tolers goal is to walk twice a day. Not assistant plan of care has been and nursing assistants have been by restorative aide on resident ambulation program.  Clinical Managers will review plans and documentation of the programs to as accurate completion of the programs.	d obesity s through of frequent e. The plan clude an ent results daily walks ance. The ursing en updated been trained it's  the care he residents ssure ogram.		
	assistant, (NA)-E, represponsible for assis program. NA-E report from physical therapy assisted to walk by hestorative nursing brwalk"  On 6/29/16 at 11:18 not walk R41 very of in his room. Otherwisto walk. NA-D report walking R41.  On 6/29/16 at 12:25	ting R41 with a walking ted when R41 discharged y, he was assigned to be is floor nursing assistant, not ecause he was an "easy a.m., NA-D reported she did ten except from chair to bed se she was not offering him ed she thought NA-A was		The care plans are reviewed the Clinical Manager per the Fand revised as needed. Upor from physical therapy the their recommends restorative nurs ambulation programs as apprincluding program specifics for resident. Therapist also review recommended plan with the CM Manager and Restorative Aidic Clinical Manager will assure torder is in the electronic healt program specifics, create plar ambulation program, revise the assistant plan of care and program specifics. Restorative Aide a Managers will assure program and goal success.	RAI process in discharge rapists ing opriate or individual ws the Clinical e. he nursing th record with of care for ne nursing ovide training and Clinical		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245365	B. WING _			06/	/30/2016	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
CEDENITY	CADE CENTED MAD	NAM		20	0 EARL STREET			
CERENII	CARE CENTER - MAR	MAN		S	AINT PAUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 311	Continued From pag	je 13	F	311				
	recommended resto walk daily. PT-A repronsistently walk 70 by assistance at discomposition of 6/29/16 at 12:35 rehabilitation reported walking program with staff had discharged instructions to nursimprogram.  On 6/26/16 at 1:06 pt NA-D walked with Recreation room and accompanied NA-D wheelchair behind Resperience shortness completed the entire wanted to be walking abilities. R41 reported walking the halls with reported there was mare progress with R41's  On 6/29/16 at 1:43 preported RN-A should for R41's walking professional requiring assistance living] secondary to attack], bradycardia, "Resident will be ablindependently" and a sindependently" and a sindependently and a s	rative nursing program to orted R41 was able to feet at discharge with stand charge from physical therapy.  p.m., the director of ed R41 should be on a h nursing. Physical therapy him and provided ag staff on the walking  p.m., per surveyor request, 41 from his room around the back to his room. RN-A and R41, rolling R41's 41. R41 was noted to s of breath but persisted and route. R41 reported he g again to keep his skills and ed this was only his 7th time in nursing staff. RN-A again to system to monitor restorative nursing program.  p.m., the director of nursing lid be monitoring the progress gram on a quarterly basis.  p.m., dated 12/11/2015, "Mobility Deficit resident with ADLs [activities of daily NSTEMI [type of heart weakness" with a goal e to ambulate/transfer an intervention "Provide stand-by to extensive, for uraging as much			Audits will be completed on current residents with restorative ambulation programs weekly times four weeks by clinical manager or designee and then deemed necessary based on results. Taudit will include the care plan for appropriateness of the program and the goals, resident participation and completion of documentation.  Analysis of the observations and facilit compliance will be presented to our quality improvement team and approve by the Administrator. The quality improvement team will implement need changes and determine the need for ongoing monitoring/ auditing after analysis. The Director of Nursing is responsible for this plan of correction.	Γhe e y ed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245365	B. WING_			06/	30/2016	
NAME OF PROVIDER OR SUPPLIER  CERENITY CARE CENTER - MARIAN				20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EARL STREET AINT PAUL, MN 55106			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 311	Continued From page 14		F:	311				
	undated, directed staresident AM [morning Walker, belt and follow A review of R41's PT-Discharge Summary, "Recommendations dinclude Ambulation prosupervision with all mambulates 70 feet with wheeled walker with worder to complete fundation Review of Point of Camany times R41 walk discharge from physic March 2016, R41 was at least once on 21 description."	and PM [afternoon]: w with WC [wheelchair]"  Therapist Progress and dated 2/29/16, revealed iscussed with Patient ogram, standing program, obility" and "patient h stand by assist and 4 verbal instruction/cues in ctional mobility"  The History revealed how ed each month following cal therapy on 2/29/16. In a sassisted to walk in corridor ays out of 31 days. In April						
	2016, R41 was assist least once on 10 days 2016, R41 was assist least once on 4 days 6/30/16) R41 was assist least once on 5 days  Review of Progress in dated 2/29/16 to 6/30 ambulation program by reveal no review of the program by a licensed.  The BHS Well Interim directed staff, "Upon admission/re-admissistatus the resident will wellness/restorative in the same as the same	ed to walk in corridor at sout of 30 days. In May ed to walk in corridor at out of 31. In June (6/1/16 to sisted to walk in corridor at out of 30.  otes and Observations, /16 revealed no refusals of by R41. The documents e restorative nursing						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245365	B. WING			06/30/2016	
NAME OF PROVIDER OR SUPPLIER  CERENITY CARE CENTER - MARIAN				200	EET ADDRESS, CITY, STATE, ZIP CODE EARL STREET NT PAUL, MN 55106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 311 F 371 SS=F	Continued From page 15 in MatrixCare no later than the ARD [assessment reference date] for the assessment period for new admissions, readmission, or significant change in status. For quarterly MDS reassessment the licensed nurse will complete the "ADL Skills Analysis for Restorative Nursing Program" in MatrixCare during the ARD window." and "A licensed nurse will provide oversight to the program to ensure the wellness/restorative interventions are being implemented as planned." and "The RN will document at a minimum quarterly progress note indicating the progress, lack of progress, and changes to the restorative care plan during the ARD window and PRN [as needed]. Changes will be shared with staff." 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		F 371			7/29/16	
	by: Based on observatio review, the facility fail hygiene during food p was stored under sar	n, interview and document ed to ensure proper hand preparation and ensure food litary conditions. This had to the 82 residents who in the facility kitchen.			Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Complianch has been prepared and timely submitte Submission of this Credible Allegation of Complainace is not a legal admission that deficiency exists or that the Statemer of the Deficiencies were correctly sited,	ce d. of nat nt	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LTIPLE CONSTRUCTION DING		E SURVEY MPLETED
		245365	B. WING _		00	6/30/2016
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, Z		
				200 EARL STREET		
CERENIT	Y CARE CENTER - MA	ARIAN		SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 371	Continued From p	age 16	F3	371		
F 371	Findings include:  On 6/27/16 from n main kitchen walk have water drippin and containers of food were noted to 12 boxes of pies, a container of rolls. On the contents of the of food containers of food with boxes ceiling and rows or middle of the walk persons to walk the into or brushing agonal reported much since she started shand there was not freezer should be so close to the ceil reported staff may freezer open, cause cooling system. Not freezer.  During observation main kitchen on 6/ (Cook)-A was obsegloved hands, place with the properties of the ceil reported staff may freezer.	oon to 12:55 p.m. the facility in freezer was observed to g from the ceiling onto the floor food. Multiple containers of the bein wet containers; including a box of chicken fingers and a Other containers of food were lithough it was difficult to read a box as the freezer was too full. The freezer was stacked full of food within two inches of the food from the walls to the in freezer, making it difficult for rough freezer without bumping gainst boxes and bags of food. Ger (DM) confirmed findings in of the food had been there several weeks prior to survey plan to use it. DM reported the cleaned and food should not be ling and fire sprinklers. DM have left the door to the sing the water to drip from the other mometer was in the	F3	and is also not to be coradmission against interestits Administrator or any agents or other individual may be discussed in this Allegation of Compliance preparation and submission of any kind by Facility of facts alleged or the correction of any kind by Facility of facts alleged or the correction of any kind by Facility of facts alleged or the correction of the survey agency. Accession within this Credible Compliance solely becased federal law mandate sufficient of Credible Allegation of the Credible Allegation of within this time frame should be considered or construction with the allegations of madmission by the Facility Cook A was removed from the cook A was r	est of the Facility, employees, als who draft or e Credible e. In addtion, sion of this Compliance does sion or agreement of the truth of any ectness of any this allegation by ordingy, we are Allegation of a compliance within of receipt of the sas a condition to care and Medical the submission of a compliance mould in no way be does a agreement on- compliance or y. The compliance or y	
	multi-use bottles o over the raw meat seen putting the s spices. Cook-A wa	f spice and sprinkled the spice on the tray. Cook-A was later pices back with the other as observed to drop garbage on sh it down into garbage, then		Audits of food storage a completed to ensure corpolicies by Culinary Dire and Lead and documentimes/week for two weel	reas will be mpliance with ector, Supervisor ted five	

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA OPLAN OF CORRECTION  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  ———————————————————————————————————			(X3) DATE SURVEY COMPLETED		
		245365	B. WING			06/30/2016
	ROVIDER OR SUPPLIER	AN		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET SAINT PAUL, MN 55106	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	dry storage area with storage shelves for di preparation area. The the shelves and dishe confirmed he did touch handling raw meat wire washing hands and thou the shelves to use was not acceptable accontaminate whateve season next. DM dispimmediately after surreported staff should raw meat and garbagitems.  The food storage policular lood stored in a clean, covauitable protected. Coarranged so that free at all times." The Handirected staff "Therefore	and a box of flour from the cout washing hands. The shes were below the food are was dried food debris on as. At 2:20 p.m. Cook-A the the spice containers after thout changing gloves and then put the seasoning back again. DM reported this as the spices may then ar food they were used as osed of the spices are your notification. DM awash hands after handling the before handling other food act, undated, directed staff aigeration units must be containers should be circulation of air is allowed dwashing policy, undated ore, any activity, which may is, must but be followed by	F 37	/week times one month and the /week ongoing. Monitoring for hand washing and proper glov be completed ongoing by Direct Supervisor and Leads.  Analysis of the observations at compliance will be presented to quality improvement team and by the Administrator. The quality improvement team will implement changes and determine the neterongoing monitoring/auditing at analysis. The Director of Culina Services is responsible for this correction.	proper e use will ctor,  nd facility o our approved ity ent needed eed for fter ary	

F5365025

PRINTED: 07/26/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245365	B. WING			06/2	29/2016
	PROVIDER OR SUPPLIER  FY CARE CENTER - N	IARIAN		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EARL STREET AINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ΓS	K	000			
	ALLEGATION OF ( DEPARTMENT'S A SIGNATURE AT TH	COC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT ( CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departmentime of this survey, was found not to be with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National I	Survey was conducted by the nent of Public Safety. At the Cerenity Care Center Marian in substantial compliance its for participation in at 42 CFR, Subpart by from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY					
	HEALTHCARE FIR STATE FIRE MARS 445 MINNESOTA ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145			EPOC		
	Or by email to: Marian.Whitney@s Angela.Kappenmar						6
		Ř					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/25/2016

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.

Facility ID: 00354

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION - MAIN BUILDING 01		TE SURVEY MPLETED	
		245365	B. WING			06	/29/2016	
	PROVIDER OR SUPPLIER	MARIAN		200	EET ADDRESS, CITY, STATE, ZIP CODE EARL STREET INT PAUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO  1. A description of a to correct the deficiency for correct the actual, or proposed in the actual for constructed at a difficult of the actual forms of the actual forms of the actual forms of the actual forms of the corridors of the corridors of the actual forms of the corridors of the actual forms of the corridors of the corridors of the actual forms of the corridors of the actual forms of the corridors of the correct of the co	RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:  what has been, or will be, done dency.  oposed, completion date.  In title of the person rection and monitoring to dence of the deficiency.  Iter Marian is a 5-story building ment. The building was ferent times. The original fucted in 1963 and was for Type I(332) construction. In tion was constructed above has determined to be of type. In 2002 a 1 story addition was morth that was determined to detruction. Because the original dition(s) meet the construction disting buildings, the facility was uniding.  If fire sprinkler protected, The determined to retruction and spaces or, that is monitored for the determinent notification. The facility acity of 90 beds and had a	K	000				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG <b>01 - Main Building 01</b>		E SURVEY IPLETED	
		245365	B. WING _		06/	29/2016	
NAME OF PROVIDER OR SUPPLIER  CERENITY CARE CENTER - MARIAN				STREET ADDRESS, CITY, STATE, ZIP 200 EARL STREET SAINT PAUL, MN 55106	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 000	Continued From pa	nge 2	K 0	00		•,	
K 018 SS=D	NOT MET as evide	42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD	K 0	18		8/9/16	
	required enclosures hazardous areas shas those constructs core wood, or capa 20 minutes. Cleara and floor covering i in fully sprinklered s required to resist the no impediment to the open devices that repushed or pulled are provided with a medoor closed. Dutch permitted. Door framade of steel or oth with 8.2.3.2.1. Rolled CMS regulations in 19.3.6.3. This STANDARD is Based on the obsefacility had several meet the requirement Section 19.3.6.3, the or latch. This defice safety of approximation undetermined num smoke from a fire waccess corridors must be required. Findings include: On the facility tour latch.	porridor openings in other than a sof vertical openings, exits, or hall be substantial doors, such and of 13/4 inch solid-bonded able of resisting fire for at least nee between bottom of door is not exceeding 1 inch. Doors smoke compartments are only the passage of smoke. There is the closing of the doors. Hold alease when the door is the elease when the door is the permitted. Doors shall be and suitable for keeping the doors meeting 19.3.6.3.6 are mes shall be labeled and ther materials in compliance are latches are prohibited by all health care facilities.  In somet as evidenced by: the evidence of NFPA 101 LSC (00) and the protection of the frame interpractice could affect the ately 34 of 90 residents and an and ber of staff and visitors, if were allowed to enter the exit aking it untenable.		Cerenity Senior Care - Ma Paul's Credible Allegation of has been prepared and tim Submission of this Credible Complainace is not a legal a deficiency exists or that to of the Deficiencies were cound is also not to be constadmission against interest its Administrator or any emagents or other individuals may be discussed in this Callegation of Compliance. preparation and submission	of Compliance nely submitted. e Allegation of admission that the Statement brectly sited, rued as an of the Facility, aployees, who draft or Credible In addtion,		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION : 01 - MAIN BUILDING 01		E SURVEY PLETED
		245365	B. WING		06/	29/2016
NAME OF PROVIDER OR SUPPLIER  CERENITY CARE CENTER - MARIAN			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET SAINT PAUL, MN 55106	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 018			K 018	not contsitute an admission or a of any kind by Facility of the trutt facts alleged or the correctness conclusions set forth in this alleg the survey agency. Accordingy, submitting this Credible Allegatic Compliance solely because stat federal law mandate submission Credible Allegation of Compliance ten(10) calendar days of receipt Statement of Deficincies as a coparticopate in the Medicare and Assistance programs. The submithe Credible Allegation of Compwithin this time frame should in considered or construed as agrewith the allegations of non-comadmission by the Facility. Environmental Services Staff (Ecorrected Rooms 505 and 206B staff will check all facility doors flatching. These checks have be to the facility preventative maint program for ongoing assurance door latching. The Director of Evoring results of these checks to improvement team for review. Decorrection.	of any of any of any of any of any gation by we are on of a ce within of the ondition to Medical hission of liance no way be element pliance or VS)  EVS or proper en added enance of proper VS will the quality pirector of	
K 025 SS=F	Smoke barriers shalleast a one half hor constructed in accordantiers shall be performed with the barriers shall be performed. Windowstre-rated glazing of steel frames.  8.3, 19.3.7.3, 19.3.	all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an ws shall be protected by r by wired glass panels and 7.5 is not met as evidenced by:	K 025			7/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 01 - Main Building 01		(X3) DATE SURVEY COMPLETED	
		245365	B. WING		06/	29/2016	
	PROVIDER OR SUPPLIER	MARIAN		STREET ADDRESS, CITY, STATE, ZIP CO 200 EARL STREET SAINT PAUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 025	Based on observa facility failed to ma accordance with th 2000 NFPA 101, So The deficient pract patients and an unand visitors.  Findings include:  On the facility tour 6/29/2016 observa barriers had peneti locations:  Above ceiling at the front of room 406 thole in the corridor penetrations in the room through the sabove ceiling at the conduit running thr 231.  Above the ceiling at doors conduit runn room 218  Above the ceiling in there are penetrations where the ceiling in the penetration where the pe	tion and staff interview, the intain smoke barrier walls in e following requirements of ection 19.3.7.3, and 8.3.4.1. ice could affect 90 of the 237 determined amount of staff  between 0930 and 1230 on tions revealed that smoke rations at the following  e 4 West Wing smoke doors in here is a large 5ftx5ft square wall that reveals numerous smoke wall in the residents smoke barrier.  e 2 West Wing smoke doors ough the wall in from of room at the 2 West Wing smoke ing through the wall in from of the 5 West in front of room 520 ons in the smoke barrier wall.	K 025	Cerenity Senior Care - Mari Paul's Credible Allegation of has been prepared and time Submission of this Credible Complainace is not a legal a a deficiency exists or that the of the Deficiencies were contand is also not to be construated admission against interest of its Administrator or any empagents or other individuals we may be discussed in this Credible Allegation of Compliance. In preparation and submission Credicble Allegation of Comnot contsitute an admission of any kind by Facility of the facts alleged or the correct conclusions set forth in this the survey agency. According submitting this Credible Alle Compliance solely because federal law mandate submist Credible Allegation of Completen(10) calendar days of receivable Allegation of Compl	Compliance ely submitted. Allegation of admission that e Statement rectly sited, and as an of the Facility, alloyees, who draft or edible addition, of this pliance does or agreement truth of any allegation by allegation by agy, we are gation of state and assion of a bliance within ceipt of the a condition to and Medical submission of ompliance d in no way be agreement compliance or agree		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245365	B. WING	1		06/3	29/2016	
	PROVIDER OR SUPPLIER	IARIAN		20	TREET ADDRESS, CITY, STATE, ZIP CODE DO EARL STREET AINT PAUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K 025	Continued From pa	ige 5	Κ0	25	preventative maintenance program includes the inspection of all smok barrier walls too assure proper cau as needed.  EVS Director is responsible for compliance of this plan of corrections.	e ulking		
K 062 SS=E	Required automatic continuously mainta condition and are in periodically. 19.7 9.7.5 This STANDARD is Based on observational complete automatic being maintained in 25(99) Section 9.2. effect all patients.  Findings include: On facility tour betw 06/29/2016, observed heads in the dishward corroded.	sprinkler systems are ained in reliable operating aspected and tested 1.6, 4.6.12, NFPA 13, NFPA 25, as not met as evidenced by: tion and interview, the crire sprinkler system is not accordance with NFPA 7. This deficient practice could eveen 0930 and 1230 on ration revealed that 7 sprinkler asher room were severely dice was verified by the Director ervices (PF)	KO	62	Cerenity Senior Care - Marian of Paul's Credible Allegation of Comphas been prepared and timely sub Submission of this Credible Allega Complainace is not a legal admiss a deficiency exists or that the Statiof the Deficiencies were correctly and is also not to be construed as admission against interest of the Fits Administrator or any employees agents or other individuals who drawy be discussed in thie Credible Allegation of Compliance. In additional preparation and submission of this Credicble Allegation of Compliance of any kind by Facility of the truth of acts alleged or the correctness of conclusions set forth in this allegatine survey agency. Accordingly, we submitting this Credible Allegation Compliance solely because state of the correctness of conclusions against the survey agency. Accordingly, we submitting this Credible Allegation Compliance solely because state of the correctness of conclusions of the correctness of conclusions against the survey agency. Accordingly, we submitting this Credible Allegation Compliance solely because state of the correctness of the correctness of conclusions against the correctness of conclusions are forth in this allegation Compliance solely because state of the correctness of the correctness of conclusions against the correctness of conclusions are forth in this allegation compliance solely because state of the correctness of the correctness of conclusions and correctness of conclusions are conclusions as a conclusion of the correctness of the cor	coliance mitted. Ition of sion that ement sited, an facility, s, aft or on, see does eement of any tion by e are of and of a within f the	8/9/16	

MAME OF PROVIDER OR SUPPLIER  CERENITY CARE CENTER - MARIAN  STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET SAINT PAUL, MN 55108  FROM DESCRIPTION  (EACH DEFCIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K 062  Continued From page 6  Continued From page 6  Continued From page 6  K 062  Continued From page 6  Continued From page 6  Continued From page 6  K 062  Continued From page 6  Continued From page 8  Continued From page 9  Co		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
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particopate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non- compliance or admission by the Facility.  The seven sprinkler heads in dish room were replaced on 7/22/16.Environmental Services Staff (EVS) completed inspection of facility sprinkler heads to identify others needing replacement. We will replace corroded sprinkler heads as needed.  Our annual fire system inspection will include checking and replacing corroded	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE	
	K 062	Continued From pa	ge 6	K 06	particopate in the Medicare and Me Assistance programs. The submiss the Credible Allegation of Complian within this time frame should in no considered or construed as agreer with the allegations of non-complicadmission by the Facility. The seven sprinkler heads in dish were replaced on 7/22/16.Environt Services Staff (EVS) completed inspection of facility sprinkler head identify others needing replacement will replace corroded sprinkler head needed.  Our annual fire system inspection include checking and replacing continuation.	sion of nce way be nent ance or room nental s to ds as will		



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 15, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5365025

Dear Ms. Juday Barnett:

The above facility was surveyed on June 27, 2016 through June 30, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Cerenity Care Center - Marian July 15, 2016 Page 2

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss at (651) 201-3793 or email: susanne.reuss@state.mn.us.

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

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

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

(X6) DATE

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00354	B. WING		06/30/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
CERENITY	CARE CENTER - MARIA	AN	STREET AUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 000	000 Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart.  Determination of where corrected requires contended requires contended and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been mpliance with all			
	that may result from norders provided that at the Department within notice of assessment  INITIAL COMMENTS You have agreed to preceipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/25/16 **Electronically Signed** 

TITLE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00354	B. WING		06/30/2016	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
CERENIT	Y CARE CENTER - MARIA	AN 200 EARL	STREET JL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPL	ETE
2 000	you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department On June 27th, 28th, 2 surveyors of this Depabove provider and the orders are issued. Ple electronic plan of correviewed these orders they will be completed. Minnesota Department the State Licensing Confederal software. Tag assigned to Minnesota Nursing Homes.  The assigned tag nur column entitled "ID Festatute/rule out of consummary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following are the Suggested McTime period for Correction Correctio	orders being submitted to though no plan of correction a Statutes/Rules, please cted" in the box available for idicate in the electronic iss, under the heading date your orders will be ctronically submitting to the int of Health.  19th and 30th 2016, artment's staff, visited the interpretation of the essential in your rection that you have is, and identify the date when id.  10th of Health is documenting orrection Orders using numbers have been a state statutes/rules for in the representation of the state in the of Deficiencies" column Comply" portion of the column also includes the violation of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction.  In the tendence of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction.	2 000			
	"PROVIDER'S PLAN	OF CORRECTION." THIS ALL DEFICIENCIES ONLY				

Minnesota Department of Health

STATE FORM 6899 KDU311 If continuation sheet 2 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00354	B. WING		06/30/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE	
CERENIT	Y CARE CENTER - MARIA	AN	STREET LUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Continued From page	2	2 000		
	THIS WILL APPEAR	ON EACH PAGE.			
	· ·	IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.			
2 560	MN Rule 4658.0405 S Plan of Care; Content	Subp. 2 Comprehensive	2 560		7/21/16
	objectives and timetal long- and short-term of and mental and psychidentified in the compassessment. The commust include the indiv	of care must list measurable bles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident mprehensive plan of care vidual abuse prevention plan a Statutes, section 626.557,			
	by: Based on observation interview, the facility of	t is not met as evidenced  n, document review, and did not accurately identify the the plan of care for 1 of 1 ed for dialysis.		Corrected	
	Findings include:				
	10:39 a.m. R19 was a dialysis access site. area on her upper, lef covered with a dressi catheter port under th site for dialysis. The surveyor her right fore shunt on her right fore	R19's room on 6/30/16, at asked the location of her The resident pointed to an it chest area that was ing and stated that the e dressing was her access resident then showed the earm and stated that the earm was an old access site ins and it is not used for her			

Minnesota Department of Health

STATE FORM 6899 KDU311 If continuation sheet 3 of 21

Minnesot	ta Department of Health	1				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00354	B. WING		06/30	0/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CERENIT	Y CARE CENTER - MARIA	AN 200 EARL SAINT PAI	STREET UL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 560	Continued From page	3	2 560			
	dialysis.					
	dated 3/1/16, that rea undated Dialysis Care Shunt: Right Arm," wi port. The Treatment June 2016 contained check the bruit/thrill a the fistula site every smonitoring the port sit Flowsheet contained access site for rednes [three times daily] [sidexplanation of the loc The current care plan contained a problem freceives hemodialysis approaches for this pubruit/thrill at shunt site shunt site, and observinfection, with no direction, with no direction access site. One [blood pressure] on RWhen interviewed on registered nurse (RN) of the dialysis access that he was not sure, be in the resident's dibinder was reviewed identification or location During interview, on on ursing assistant (NA of R19's dialysis access and sure but she on her right arm. RN-A was interviewed p.m. and asked if their documentation of the	te. The Medication an entry that read, "Monitor as bleeding or swelling tid c]," with no further ation of the access site. for R19, dated 5/31/16, that read, "Resident as 3 times weekly" The roblem included checking a, managing bleeding at ving the access site for ction as to the location of approach read, "No B/P aggregation of the dialysis and did not contain on of the dialysis chest port. 6/30/16 at 11:51 a.m., a)-C was asked the location ass site and replied that she believed R19 had a shunt  diagain on 6/30/16 at 2:18				

STATE FORM 6899 KDU311 If continuation sheet 4 of 21

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00354	B. WING		06/30/2016	
	ROVIDER OR SUPPLIER Y CARE CENTER - MARI	AN 200 EAR	DDRESS, CITY, STA L STREET AUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 560	has a left chest port for was cognitively able to dialysis access site. SUGGESTED METH The director of nursing develop and implement related to developing. The DON or designerall nursing staff. The assurance committee audits to ensure committee audits to ensure committee.	e was now aware that R19 or dialysis access and R19 to accurately describe her  OD OF CORRECTION: g (DON) or designee, could ent policies and procedures a comprehensive care plan ee, could provide training for quality assessment and e could perform random	2 560			
2 565	Plan of Care; Use Subp. 3. Use. A con must be used by all p care of the resident.	Subp. 3 Comprehensive  Inprehensive plan of care ersonnel involved in the  It is not met as evidenced	2 565		7/21/16	
	by: Based on observatior review, the facility fail for restorative nursing	n, interview, and document ed to ensure the care plan g services was followed for 1 eviewed for ambulation.		Corrected		
	revealed a problem "I requiring assistance v	plan, dated 12/11/2015, Mobility Deficit resident with ADLs [activities of daily				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00354	B. WING		06/30	)/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
CERENIT	Y CARE CENTER - MARI	AN 200 EARL S SAINT PAU	L, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	attack], bradycardia, "Resident will be able independently" and a required assistance, smobility, while encour independence as able Review of the Nursing undated, directed staresident AM [morning Walker, belt and follow On 6/27/16 at 5:58 p. supposed to be assis walking at least daily, happening on a regul On 6/29/16 at 8:53 a. (NA)-D, reported she walking program with a.m. NA-D reported soften except from chat Otherwise she was not reported she thought On 6/29/16 at 10:55 a manager, (RN)-A reported she thought On 6/29/16 at 11:05 a manager, it was not way to know if it was offered.  On 6/29/16 at 11:05 a assistant, (NA)-E, represponsible for walking R41 discharged from assigned to be walked.	weakness" with a goal to ambulate/transfer in intervention "Provide stand-by to extensive, for raging as much e."  g Assistant Care Sheet, ff "Offer to ambulate ] and PM [afternoon]: w with WC [wheelchair]"  m., R41 reported he was ted by nursing staff with but reported that was not ar basis.  m., R41's nursing assistant, was not currently doing a R41. On 6/29/16 at 11:18 he did not walk R41 very air to bed in his room. of offering him to walk. NA-D NA-A was walking R41.  a.m., the clinical nurse orted if the point of care ted the walking was not completed. There was no offered and refused or not  a.m., the restorative nursing orted she was not ng R41. NA-E reported when physical therapy, he was	2 565			

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PRINTED: 08/02/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00354	B. WING		06/3	30/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CERENIT	Y CARE CENTER - MARIA	AN 200 EARL: SAINT PAU	STREET JL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	NA-D walked with R4 recreation room and be accompanied NA-D as wheelchair behind R4 experience shortness completed the entire wanted to be walking and skills up. R41 reptime walking the halls.  Review of Point of Camany times R41 walk discharge from physic March 2016, R41 was at least once on 21 d 2016, R41 was assist least once on 10 days 2016, R41 was assist least once on 4 days (6/1/16 to 6/30/16) R4 corridor at least once.  Review of Progress in dated 2/29/16 to 6/30 related to R41 refusion.  SUGGESTED METH The director of nursin review and revise pol to ensuring the care president is followed. designee could devel and develop a monitor are providing care as of care.	m., per surveyor request, 1 from his room around the back to his room. RN-A and R41, rolling R41's 1. R41 was noted to 1 of breath but persisted and route. R41 reported he again to keep his abilities borted this was only his 7th with nursing staff.  are History revealed how and each month following bal therapy on 2/29/16. In as assisted to walk in corridor alays out of 31 days. In April and the walk in corridor at a out of 30 days. In May and the walk in corridor at a out of 31 days. In June 31 was assisted to walk in	2 565			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIL	LILD
		00354	B. WING		06/3	0/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CERENITY	CARE CENTER - MARI	AN 200 EARL S				
			L, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	receive nursing care a custodial care, and su individual needs and the comprehensive replan of care as described 4658.0405. A nursing of bed as much as powritten order from the	eneral. A resident must and treatment, personal and upervision based on preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out essible unless there is a attending physician that the in bed or the resident	2 830			7/21/16
	by: Based on observation interview, the facility of dialysis access site in resident (R19) review  Findings include:  During observation in 10:39 a.m. R19 was a dialysis access site. area on her upper, left covered with a dressi catheter port under the site for dialysis. The surveyor her right foreshunt on her right foreshunt on her right forestimeters.	R19's room on 6/30/16, at asked the location of her The resident pointed to an		Corrected		
	Record review reveal	ed a physician's order,				

Minnesota Department of Health

STATE FORM 6899 KDU311 If continuation sheet 8 of 21

Minnesot	a Department of Health	1			1 Ordivi	ALLINOVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
		00354	B. WING		06/3	0/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	JE ZIP CODE		
		200 EARL		,		
CERENITY	CARE CENTER - MARIA	AN	UL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	dated 3/1/16, that rea undated Dialysis Care Shunt: Right Arm," wir port. The Treatment June 2016 contained check the bruit/thrill at the fistula site every smonitoring the port sit Flowsheet contained access site for rednes [three times daily] [sic explanation of the loc The current care plan contained a problem to receives hemodialysis approaches for this probuit/thrill at shunt site shunt site, and observinfection, with no direct the access site. One [blood pressure] on R	d, "Dialysis: M-W-F" An e Plan read, "Location of the chest Administration History for entries that directed staff to and monitor for bleeding at hift, with no entry for e. The Medication an entry that read, "Monitor is bleeding or swelling tid ]," with no further ation of the access site. for R19, dated 5/31/16, that read, "Resident is 3 times weekly" The roblem included checking e, managing bleeding at ving the access site for ction as to the location of approach read, "No B/P IGHT arm."	2 830			
	registered nurse (RN) of the dialysis access that he was not sure, be in the resident's dibinder was reviewed a identification or location During interview, on 60 nursing assistant (NA of R19's dialysis accewas not sure but she on her right arm.	on of the dialysis chest port.  3/30/16 at 11:51 a.m.,  3-C was asked the location  3-c site and replied that she  3-d believed R19 had a shunt  3-d again on 6/30/16 at 2:18				

documentation of the dialysis access site for R19, and he replied that he was not aware of any other documentation, but he was now aware that R19 has a left chest port for dialysis access and R19 was cognitively able to accurately describe her

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00354	B. WING		06/30/2016
	ROVIDER OR SUPPLIER Y CARE CENTER - MARI	AN 200 EAR	DDRESS, CITY, STA L STREET AUL, MN 55106	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 830	The director of nurse current dialysis polici assessment and time dialysis access site. to ensure compliance the quality committee	OD OF CORRECTION: s could educate staff on the es and procedures of proper ely interventions related to An audit could be completed and the results brought to	2 830		
2 915	Subp. 6. Activities of comprehensive resid home must ensure the A. a resident is got reatments and service abilities in activities of deterioration is a normal the resident's conditional part, activities of daily resident's ability to:  (1) bathe, dress (2) transfer and (3) use the toiled (4) eat; and	iven the appropriate ces to maintain or improve f daily living unless mal or characteristic part of on. For purposes of this v living includes the , and groom; ambulate; ;; language, or other	2 915		7/21/16
	by: Based on observation	nt is not met as evidenced n, interview, and document led to provide restorative		Corrected	

Minnesota Department of Health

STATE FORM 6899 KDU311 If continuation sheet 10 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
	00354	B. WING		06	6/30/2016
NAME OF PROVIDER OR SUPPLIER  CERENITY CARE CENTER - MA	200 EAF	ADDRESS, CITY, STATE	, ZIP CODE		
CEREMITI CARE CENTER - MA	SAINT F	PAUL, MN 55106			
PREFIX (EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
ability following disfor 1 of 1 residents  Findings include:  Review of the most ([MDS) quarterly a revealed R41 was revealed R41 requassistance to walk performance level R41 walked only cassessment reference.  On 6/27/16 at 5:58 supposed to be as daily, but recalled only six times in the On 6/29/16 at 8:53 (NA)-D, reported services R41 with a walking.  On 6/29/16 at 9:31 (LPN)-A reported letter restorative nur the restorative nur the restorative nur and she was not recompletion of daily.  On 6/29/16 at 10:5 manager, (RN)-A, walking program. RN-A rejected letter completion of daily.	o maintain or improve walking scharge from physical therapy, is (R41) reviewed for walking.  It recent minimum data set assessment, dated 5/20/16, cognitively intact. The MDS irred one person physical on corridor. The self could not be determined as ance or twice during the ence period (7 days).  It provides the period of the was assisted with walking at least being assisted with walking e last three months.  It a.m., R41's nursing assistant, the was not currently assisting grogram.  It a.m., R41's floor nurse, R41 did a walking program with sing assistant. LPN-A reported sing assistant documented it esponsible for monitoring the	2 915			

Minnesota Department of Health

STATE FORM 6899 KDU311 If continuation sheet 11 of 21

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION		SURVEY PLETED
		00354	B. WING		0.6	3/30/2016
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		1 06	13012016
		200 EAR	L STREET	TE, ZII GODE		
CERENITY	Y CARE CENTER - MARI	AN SAINT PA	AUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 915	responsible for the wareported if the point of indicated the walking not completed. There was offered and refus was no monitoring of walking occurred or mestorative nursing as the walking program.  On 6/29/16 at 11:05 assistant, (NA)-E, represponsible for assist program. NA-E reported from physical therapy assisted to walk by hir restorative nursing be walk."  On 6/29/16 at 11:18 anot walk R41 very oft in his room. Otherwisto walk. NA-D reported walking R41.  On 6/29/16 at 12:25 ptherapist, (PT)-A, reprecommended restorative walk adaily. PT-A reported walk and the program with staff had discharged instructions to nursing program.	alking program. RN-A of care documentation was not completed, it was was no way to know if it sed or not offered. There distance walked, just if not. RN-A reported the esistant was responsible for  a.m., the restorative nursing corted she was not ing R41 with a walking ted when R41 discharged or, he was assigned to be is floor nursing assistant, not ecause he was an "easy  a.m., NA-D reported she did en except from chair to bed he she was not offering him ed she thought NA-A was  a.m., R41's physical orted R41 discharged with a ative nursing program to orted R41 was able to feet at discharge with stand harge from physical therapy.  b.m., the director of d R41 should be on a nursing. Physical therapy him and provided g staff on the walking	2 915	BLI IGIENC	.,	
	On 6/26/16 at 1:06 p.	m., per surveyor request,				

Minnesota Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
, and i brain	J. JOHNLOHOM	.SERTH TO A TOTAL HOMBER.	A. BUILDING:		JOHN LETED	
		00354	B. WING		06/30/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CERENIT	Y CARE CENTER - MARI	AN 200 EARL				
	I		UL, MN 55106			$\dashv$
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	Έ
2 915	Continued From page	e 12	2 915			
2 915	NA-D walked with R4 recreation room and la accompanied NA-D a wheelchair behind R4 experience shortness completed the entire wanted to be walking abilities. R41 reported walking the halls with reported there was no progress with R41's roon 6/29/16 at 1:43 p. reported RN-A should of R41's walking progress with R41's revealed a problem "I requiring assistance valving] secondary to Nattack], bradycardia, "Resident will be able independently" and a required assistance, smobility, while encour independence as able Review of the Nursing undated, directed staresident AM [morning Walker, belt and follow A review of R41's PT-Discharge Summary, "Recommendations of	1 from his room around the back to his room. RN-A and R41, rolling R41's 11. R41 was noted to a of breath but persisted and route. R41 reported he again to keep his skills and at this was only his 7th time nursing staff. RN-A again a system to monitor estorative nursing program.  m., the director of nursing a be monitoring the progress gram on a quarterly basis.  plan, dated 12/11/2015, Mobility Deficit resident with ADLs [activities of daily ISTEMI [type of heart weakness" with a goal at to ambulate/transfer in intervention "Provide stand-by to extensive, for raging as much e"  g Assistant Care Sheet, ff "Offer to ambulate	2 915			
		h stand by assist and 4				
	wheeled walker with vorder to complete fun	verbal instruction/cues in ctional mobility"				

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
7.11.2.1.27.11.1	5. GGTLGTGT.		A. BUILDING: _			
		00354	B. WING		06/30/20	16
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
		200 EAR	L STREET			
CERENIT	Y CARE CENTER - MARI	AN	AUL, MN 55106			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE CO	DMPLETE DATE
2 915	Continued From page	e 13	2 915			
	many times R41 walk discharge from physic March 2016, R41 was at least once on 21 of 2016, R41 was assist least once on 10 days 2016, R41 was assist least once on 4 days 6/30/16) R41 was assist least once on 5 days Review of Progress in dated 2/29/16 to 6/30 ambulation program by a licensed The BHS Well Interim directed staff, "Upon admission/re-admissi status the resident will wellness/restorative in the status of the	notes and Observations, 1/16 revealed no refusals of by R41. The documents be restorative nursing				
	reference date] for the	r than the ARD [assessment e assessment period for dmission, or significant				
	change in status. For					
		sis for Restorative Nursing				
		are during the ARD window."				
		e will provide oversight to the				
	program to ensure the	e wellness/restorative				
	interventions are bein	ng implemented as planned."				
	and "The RN will doc	ument at a minimum				
	, ,, ,	te indicating the progress,				
		changes to the restorative				
		ARD window and PRN [as II be shared with staff."				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00354	B. WING		06/30/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ITE, ZIP CODE		
CERENITY	CARE CENTER - MARIA	AN	STREET			
040.45	CLIMANA DV. CT	ATEMENT OF DEFICIENCIES	UL, MN 55106	PROVIDER'S PLAN OF CORRECTIO	N OZE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
2 915	Continued From page	: 14	2 915			
24000	The director of nursing review and revise politon ensuring the resident to the rehabilitation ploor designee could devistaff and develop a most aff are providing amount of the period o	CORRECTION: Twenty-one	24000		704440	
21000	wash their hands and	ietary staff must thoroughly the exposed portions of	21000		7/21/16	
	washing facility before as often as is necessarafter smoking, eating,	and warm water in a hand e starting work, during work ary to keep them clean, and drinking, using the toilet, or ment or utensils. Dietary fingernails clean and				
	by: Based on observation review, the facility fail consistently followed	t is not met as evidenced  i, interview and document ed to ensure dietary staff appropriate hand hygiene in the potential to affect all 82 od from the dietary		Corrected		
	main kitchen on 6/27/	food preparation during 16 from noon to 12:55 p.m., I to handle raw meat with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	COMPLETED			
00354			B. WING		06/30/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		200 EARL				
CERENITY	CARE CENTER - MARIA	AN SAINT PA	UL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
21000	Continued From page	: 15	21000			
	gloved hands, placing cuts of meat onto trays. Without washing hands or changing gloves Cook- A then grabbed the open top and sides of two multi-use bottles of spice and sprinkled the meat on the tray. Cook-A was later seen putting the spices back with the other spices. Cook-A was observed to drop garbage on floor, pick it up, push it down into the garbage can, and then retrieve cans of fruit and a box of flour from the dry storage area without washing hands. The storage shelves for dishes were below the food preparation area. There was dried food debris on the shelves and dishes. At 2:20 p.m. Cook-A confirmed he did touch the spice containers after handling raw meat without changing gloves and washing hands and then put the seasoning back on the shelves to use again. The dietary manager (DM) reported this was not acceptable as the spices may then contaminate whatever food they were used to season next. DM disposed of the spices immediately after surveyor notification. DM reported staff should wash hands after handling raw meat and garbage before handling other food items.  The Handwashing policy, undated directed staff					
	"Therefore, any activi	olicy, undated directed staff ty, which may contaminate the followed by thorough				
	The dietary manager develop, review or reveducation for staff regappropriate hand hyg Quality Assessment a	iene in the kitchen. The				

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TIME PERIOD FOR CORRECTION: Twenty-one

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00354	B. WING		06/30/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE	
CERENITY	CARE CENTER - MARIA	AN	STREET AUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21000	Continued From page	: 16	21000		
	(21) days.				
21100	Storage of Perishable Subp. 5. Storage of		21100		7/21/16
	washable, corrosion-r	esistant shelving under nd at temperatures which			
	This MN Requirement is not met as evidenced by:  Based on observation, interview and document review, the facility failed to ensure food was stored under sanitary conditions. This had the potential to impact 82 of the 82 residents who ate or drank food from the facility kitchen.			Corrected	
	Findings include:				
	main kitchen walk in f have water dripping fr and containers of food food were noted to be 12 boxes of pies, a bo container of rolls. Oth noted to be wet, althouthe contents of the bo of food containers. The of food with boxes of ceiling and rows of food middle of the walk in the persons to walk throuthout or brushing again. The dietary manager and reported much of	to 12:55 p.m. the facility reezer was observed to from the ceiling onto the floor d. Multiple containers of the in wet containers; including fox of chicken fingers and a fer containers of food were flow that was difficult to read for as the freezer was too full flood within two inches of the freezer, making it difficult for the freezer without bumping st boxes and bags of food.  (DM) confirmed findings the food had been there flood in the weeks prior to survey			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE COM			SURVEY LETED	
		00354	B. WING		06/	30/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
CERENIT	Y CARE CENTER - MARI	AN	L STREET AUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21100	and there was no plat freezer should be cles so close to the ceiling reported staff may ha freezer open, causing cooling system. No the freezer.  The food storage poli "All food stored in refistored in a clean, cowsuitable protected. Coarranged so that free at all times."  SUGGESTED METH The dietary director opolicies related to sto areas of potential condirector could provide and monitor for contin	n to use it. DM reported the aned and food should not be and fire sprinklers. DM ve left the door to the at the water to drip from the termometer was in the acceptance of the container or otherwise containers should be circulation of air is allowed.  OD FOR CORRECTION: ould review and revise rage and thawing of food in thamination. The dietary election of sprinklers and to the container or otherwise rage and thawing of food in thamination. The dietary election is allowed.	21100			
21426	Prevention And Control  (a) A nursing home production and programmation a comprehes infection control programmation current tuberculosis in issued by the United Control and Prevention Tuberculosis Eliminat Morbidity and Mortality This program must in	provider must establish and insive tuberculosis ram according to the most infection control guidelines. States Centers for Disease on (CDC), Division of ion, as published in CDC's ty Weekly Report (MMWR). clude a tuberculosis that covers all paid and	21426			7/21/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00354	B. WING 06/3			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CERENIT	Y CARE CENTER - MARIA	AN 200 EARLS SAINT PAU	STREET JL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
21426	Continued From page	18	21426			
	Health shall provide to regarding implementa	tion of the guidelines.				
	by: Based on interview and facility failed to docume tuberculosis skin test of 5 residents (R16, Freviewed for TB screen ensure completion of for Nursing Home and Residents for 1 of 5 residents for	the facility on 1/12/16. R16's did not indicate dates when tep TST were given. 1/15/16, indicated "Mantoux duration; face sheet 2nd step TST dated ate negative results.  the facility on 2/19/16. R19's did not indicate dates when tep TST were given.		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00354	B. WING		06	6/30/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CERENIT	Y CARE CENTER - MAR	IAN	RL STREET AUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21426	R114 was admitted to R114's immunization when the first TST or given. The 1st step 1 did not indicate negative results.  R121 was admitted to R121's immunization dates when the first a given.  R138 was admitted to R138's immunization dates when the first a given.  Progress note "1st step Mantoux renote dated 1/31/16, in read on LFA, Omm, to Baseline TB Screeni addition, 1st and 2nd negative results.  On 6/30/16, at 3:19 proceeding (DON) verified R114 and would follow-up p.m. DON stated her documentation including induration and a posindicated the facility of Department of Health The MDH policy provindicated "each facility procedures to address TST documentation the date (i.e., month, millimeters of induration document "0" mm), a positive or negative).	o the facility on 3/10/16. record did not indicate date record step TST was TST reading dated 3/13/16, ative results.  o the facility on 3/17/16 in record did not indicate and second step TST were not the facility on 1/18/16. In record did not indicate and second step TST were not dated 1/21/16, indicated and on RFA 0mm." Progress indicated "2nd step mantoux updated on face sheet." The ing was not completed. In the step TST did not indicate no	21426			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  200 EARL STREET SAINT PAUL, MN 55106  SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST RE PRECEDER BY TRUIL, REGULATORY OR LSC IDENTIFYING INFORMATION)  21426  Continued From page 20  Step, TST-Second Step Date and time administered Results (read between 48-72 hours) Number of mm of induration: (across forearm) Interpretation of resulting* (circle) Positive** Negative***."  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED					
NAME OF PROVIDER OR SUPPLIER  CERENITY CARE CENTER - MARIAN  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21426  Continued From page 20  Step, TST-Second Step Date and time administered Results (read between 48-72 hours) Number of mm of induration: (across forearm) Interpretation of resulting* (circle)  Positive** Negative***. "  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.  TIME PERIOD FOR CORRECTION: Twenty-one				A. BOILDING.						
CERENITY CARE CENTER - MARIAN  200 EARL STREET SAINT PAUL, MN 55106  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21426  Continued From page 20 Step, TST-Second Step Date and time administered Results (read between 48-72 hours) Number of mm of induration: (across forearm) Interpretation of resulting* (circle) Positive** Negative***. "  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.  TIME PERIOD FOR CORRECTION: Twenty-one	00354 B. WING				06/30/2016					
CERENTY CARE CENTER - MARIAN  SAINT PAUL, MN 55106  (X4) ID PREFIX TAG  CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21426  Continued From page 20  Step, TST-Second Step Date and time administered Results (read between 48-72 hours) Number of mm of induration: (across forearm) Interpretation of resulting* (circle) Positive** Negative***. "  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.  TIME PERIOD FOR CORRECTION: Twenty-one	NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE    21426   Continued From page 20   Step, TST-Second Step Date and time administered Results (read between 48-72 hours) Number of mm of induration: (across forearm) Interpretation of resulting* (circle) Positive** Negative***. "    SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.    TIME PERIOD FOR CORRECTION: Twenty-one	CERENITY	CERENITY CARE CENTER - MARIAN								
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21426  Continued From page 20  Step, TST-Second Step Date and time administered Results (read between 48-72 hours) Number of mm of induration: (across forearm) Interpretation of resulting* (circle) Positive** Negative***. "  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.  TIME PERIOD FOR CORRECTION: Twenty-one				L, MN 55106						
Step, TST-Second Step Date and time administered Results (read between 48-72 hours) Number of mm of induration: (across forearm) Interpretation of resulting* (circle) Positive** Negative***. "  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.  TIME PERIOD FOR CORRECTION: Twenty-one	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE			
	21426	Step, TST-Second Stadministered Resul hours) Number of m forearm) Interpretate Positive** Negative***  SUGGESTED METH director of nursing or review/revise policies Tuberculosis screening ensure the policy was TIME PERIOD FOR O	cep Date and time ts (read between 48-72 nm of induration: (across ion of resulting* (circle) *. "  OD OF CORRECTION: The designee, could on resident and employee ng and perform audits to s being followed.	21426	DEPICIENCY)					

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