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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KDU3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00354

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245365**

2.STATE VENDOR OR MEDICAID NO.
(L2) **723816900**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - MARIAN**
(L4) **200 EARL STREET**
(L5) **SAINT PAUL, MN** (L6) **55106**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/19/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:
___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 08/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 08/30/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/13/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/09/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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.

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

MDH
Minnesota
Department
of Health

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.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245365 Y1	A. Building B. Wing Y2	8/19/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	08/04/2016	LSC	08/04/2016	LSC	08/04/2016
ID Prefix F0309	Correction	ID Prefix F0311	Correction	ID Prefix F0371	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.35(i)	Completed
LSC	08/04/2016	LSC	08/04/2016	LSC	08/04/2016
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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 08/30/2016	SIGNATURE OF SURVEYOR 34986	DATE 08/19/2016
REVIEWED BY CMS RO ☐	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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245365	A. Building 01 - MAIN BUILDING 01 B. Wing	8/25/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 08/09/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 07/25/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 08/09/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 08/30/2016	SIGNATURE OF SURVEYOR 35482	DATE 08/25/2016
REVIEWED BY CMS RO ☐	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			

MDH
Minnesota
Department
of Health

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

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

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

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

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

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
August 30, 2016

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200 Earl Street
Saint Paul, MN 55106

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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

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245365	CERENITY CARE CTR MARIAN

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

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.

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 1. 16022			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245365	CERENITY CARE CENTER - MARIAN

Type of Survey (select all that apply)

I	D	H		

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (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 identification number.

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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**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KDU3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00354

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245365**

2.STATE VENDOR OR MEDICAID NO.
(L2) **723816900**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - MARIAN**
(L4) **200 EARL STREET**
(L5) **SAINT PAUL, MN** (L6) **55106**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/30/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Capes, HFE NE II — 07/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 08/04/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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.

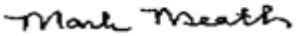
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		8/4/16

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

Electronically Signed | 07/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide an accurate initial assessment of skin conditions for 1 of 3 residents (R62) reviewed for pressure ulcers. Findings include: R62's most recent admission minimum data set (MDS) dated 5/30/16, revealed R62 was admitted to the facility on 5/23/16 and had four stage 2 pressure ulcers. The care area assessment, dated 5/30/16, revealed R62 had multiple stage 2 pressure ulcers and was on hospice care with a goal of comfort. The care area assessments refer to nurse notes, hospice notes, electronic medical administration record (EMAR), physician notes and hospital documentation. A Skin Risk Assessment with Braden Scale was completed on 5/23/16. The assessment indicated R62 was not assessed for the presence of pressure ulcers. No reason for lack of assessment of pressure ulcers was provided. A progress note, dated 5/23/16, revealed there was open areas to R62's left ankle, left small toes, left foot and right foot but no staging, type of wound or specific location.	F 278	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to particopate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance	

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F 278	Continued From page 2 R62's Individual Resident Care Plan Initiate within 24 hours of Admission, dated 5/24/16, indicated R62 had a left ankle wound at a stage 3 and unspecified wounds on right heel, and 2nd toe right foot. A nurse practitioner visit, dated 5/27/16, revealed R62 had "open wound to left foot the 4th and 5th digit" and "left open area on ankle", "peripheral vascular disease" and "unstageable area on left foot between fourth and fifth digits scabbing over. Left ankle with dressing over did not visualize today." Hospice plan of treatment addendum, dated 5/30/16 revealed "non-healing pressure ulcers of right heel and left ankle" and "new open area between 2 last toes on left foot" On 6/30/16 at 9:21 a.m. the MDS nurse (RN)-B reported he determined the presence of four stage 2 ulcers by reviewing documentation and did not observe the wounds. RN-B was unable to locate documentation stating R62 had four stage 2 ulcers. On 6/30/16 at 12:17 p.m. the director of nursing reported the admission MDS assessment may not be accurate. The Skin Risk Assessment policy, undated, directed staff "A Skin Risk Assessment Form/Braden Scale is initiated: a. On admission, or return from a hospital stay, b. Quarterly and Annually with the MDS, c. With Significant Change, d. With onset of a new pressure ulcer, e. Weekly skin assessments for a total of four weeks after admission/readmission" and "Licensed nurse will document observations from	F 278	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. R62 is an 85 year old male with a diagnosis of PMH,CAD,PVD, Alzheimer's disease ,CKD stage III and HTN. He was admitted on 5/23/16 with three pressure ulcers on lower extremities. Resident is on Hospice Care, requires total assistance with mobility and is receiving wound care. His weekly skin assessments are completed with improvement noted and without signs and symptoms of infection. The resident has a current skin risk assessment with Braden scale completed on 7/7/16.Staff member responsible for completion of the skin assessment with Braden scale completed on 5/23/16 received education on proper completion of this assessment tool. Admission process has been revised to include skin audit of boney prominences within three hours of admission by a nurse. The admission calendar has been revised to include completion of skin risk assessment with Braden scale: if skin alteration present , nurse is to notify the Clinical Manager and Wound Nurse. Nurses will complete a skin risk assessment with Braden scale weekly times four weeks on all new admissions. If there is a pressure ulcer present, our wound round team will assure weekly assessment and documentation that includes the healing progression, size, location and adequacy of the current treatment plan. Recommendations for treatment changes or plan of care	

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F 278	Continued From page 3 the resident's initial skin inspection/audit and identify any pre-existing signs of altered skin integrity." and "If a pressure ulcer is observed, a licensed nurse is notified and a Skin Event Report is completed in Matrix. A designated nurse is then informed and will initiated A Pressure Ulcer/Wound Tracking Form for each pressure ulcer and complete weekly monitoring until wound(s) resolves."	F 278	revisions will be documented and reported to the attending physician. Each resident with current pressure ulcers has been reviewed by the clinical manager to assure accurate assessment and documentation is present. When a resident is admitted to our facility the admission calendar is initiated which includes a skin risk assessment with Braden scale. The calendar has been revised to include a check every 24 hours for completion of all required assessments by the assigned nurse. All licensed nurses will be educated on the process including revision of admission calendar, completion of assessments and process of wound team notification. Audit to assure accurate completion of skin risk assessments with Braden scale for new admissions will be completed weekly by the Clinical Manager times four weeks. Wound team will assure completion accuracy of skin risk assessment with Braden scale on all admitted residents with pressure ulcers during wound rounds. This plan of correction is integrated into our quality improvement process. The audit results and analysis will be presented to our quality improvement team and approved by the Administrator. 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 this plan of correction.	

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F 279	Continued From page 4	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility did not accurately identify the dialysis access site in the plan of care for 1 of 1 resident (R19) reviewed for dialysis. Findings include: During observation in R19's room on 6/30/16, at 10:39 a.m. R19 was asked the location of her dialysis access site. The resident pointed to an area on her upper, left chest area that was covered with a dressing and stated that the	F 279	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible	8/4/16

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F 279	Continued From page 5 catheter port under the dressing was her access site for dialysis. The resident then showed the surveyor her right forearm and stated that the shunt on her right forearm was an old access site that no longer functions and it is not used for her dialysis. Record review revealed a physician's order, dated 3/1/16, that read, "Dialysis: M-W-F" An undated Dialysis Care Plan read, "Location of Shunt: Right Arm," with no mention of the chest port. The Treatment Administration History for June 2016 contained entries that directed staff to check the bruit/thrill and monitor for bleeding at the fistula site every shift, with no entry for monitoring the port site. The Medication Flowsheet contained an entry that read, "Monitor access site for redness bleeding or swelling tid [three times daily] [sic]," with no further explanation of the location of the access site. The current care plan for R19, dated 5/31/16, contained a problem that read, "Resident receives hemodialysis 3 times weekly..." The approaches for this problem included checking bruit/thrill at shunt site, managing bleeding at shunt site, and observing the access site for infection, with no direction as to the location of the access site. One approach read, "No B/P [blood pressure] on RIGHT arm." When interviewed on 6/30/16, at 11:40 a.m. registered nurse (RN)-A was asked the location of the dialysis access site for R19 and he replied that he was not sure, but that information would be in the resident's dialysis binder. The dialysis binder was reviewed and did not contain identification or location of the dialysis chest port. During interview, on 6/30/16 at 11:51 a.m., nursing assistant (NA)-C was asked the location of R19's dialysis access site and replied that she	F 279	Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to 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. R19 plan of care has been revised to include resident's specific dialysis access site in use, monitoring orders, nursing assistant care guide and nurses communication sheet. A dialysis checklist for admissions has been revised to include specific dialysis site, placing an order to monitor specific site for bruit/thrill, bleeding, redness or swelling and other treatment orders necessary. Currently there are no other residents receiving dialysis. The revised checklist will be used for all future residents on dialysis. The nurses will be educated on the revisions to the policy by August 4, 2016. This plan of correction is integrated into	

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CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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F 279	Continued From page 6 was not sure but she believed R19 had a shunt on her right arm. RN-A was interviewed again on 6/30/16 at 2:18 p.m. and asked if there was any other 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 dialysis access site.	F 279	our quality improvement process. The checklist will serve as our audit tool and the clinical managers will complete weekly audits on residents receiving dialysis for four weeks and as deemed necessary by quality committee. Analysis of the observations and facility compliance will be presented to our quality improvement team and approved by the Administrator. 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 this plan of correction.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan for restorative nursing services was followed for 1 of 1 residents (R41) reviewed for ambulation. Findings include: Review of R41's care plan, dated 12/11/2015, revealed a problem "Mobility Deficit resident requiring assistance with ADLs [activities of daily living] secondary to NSTEMI [type of heart attack], bradycardia, weakness" with a goal	F 282	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible	8/4/16

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	245365	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 "Resident will be able to ambulate/transfer independently" and an intervention "Provide required assistance, stand-by to extensive, for mobility, while encouraging as much independence as able." Review of the Nursing Assistant Care Sheet, undated, directed staff "Offer to ambulate resident AM [morning] and PM [afternoon]: Walker, belt and follow with WC [wheelchair]" On 6/27/16 at 5:58 p.m., R41 reported he was supposed to be assisted by nursing staff with walking at least daily, but reported that was not happening on a regular basis. On 6/29/16 at 8:53 a.m., R41's nursing assistant, (NA)-D, reported she was not currently doing a walking program with R41. On 6/29/16 at 11:18 a.m. NA-D reported she did not walk R41 very often except from chair to bed in his room. Otherwise she was not offering him to walk. NA-D reported she thought NA-A was walking R41. On 6/29/16 at 10:55 a.m., the clinical nurse manager, (RN)-A reported if the point of care documentation indicated the walking was not completed, it was not completed. There was no way to know if it was offered and refused or not offered. On 6/29/16 at 11:05 a.m., the restorative nursing assistant, (NA)-E, reported she was not responsible for walking R41. NA-E reported when R41 discharged from physical therapy, he was assigned to be walked by his floor nursing assistant, not restorative because he was an "easy walk"	F 282	Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to 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. R41 was admitted on 11/15/15 with a diagnosis of MI, Atrial Fib. and obesity and received therapy services through 2/29/16 with documentation of frequent refusals during that timeframe. The plan of care has been revised to include an ambulation program with current results indicating resident averaging daily walks up to 300 feet with good tolerance. The goal is to walk twice a day. Nursing assistant plan of care has been updated and nursing assistants have been trained by restorative aide on resident's ambulation program. Clinical Managers will review the care plans and documentation of the residents on ambulation programs to assure accurate completion of the program.	

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F 282	Continued From page 8 On 6/26/16 at 1:06 p.m., per surveyor request, NA-D walked with R41 from his room around the recreation room and back to his room. RN-A accompanied NA-D and R41, rolling R41's wheelchair behind R41. R41 was noted to experience shortness of breath but persisted and completed the entire route. R41 reported he wanted to be walking again to keep his abilities and skills up. R41 reported this was only his 7th time walking the halls with nursing staff. Review of Point of Care History revealed how many times R41 walked each month following discharge from physical therapy on 2/29/16. In March 2016, R41 was assisted to walk in corridor at least once on 21 days out of 31 days. In April 2016, R41 was assisted to walk in corridor at least once on 10 days out of 30 days. In May 2016, R41 was assisted to walk in corridor at least once on 4 days out of 31 days. In June (6/1/16 to 6/30/16) R41 was assisted to walk in corridor at least once on 5 days out of 30. Review of Progress notes and Observations, dated 2/29/16 to 6/30/16 revealed no concerns related to R41 refusing the walking program.	F 282	The care plans are reviewed quarterly by 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 with program specifics, create plan of care for ambulation program, revise the nursing assistant plan of care and provide training as needed. Restorative Aide and Clinical Managers will assure program completion 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 as 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 approved by the Administrator. 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 this plan of correction.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		8/4/16

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F 309	Continued From page 9 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility did not accurately identify the dialysis access site in the plan of care for 1 of 1 resident (R19) reviewed for dialysis. Findings include: During observation in R19's room on 6/30/16, at 10:39 a.m. R19 was asked the location of her dialysis access site. The resident pointed to an area on her upper, left chest area that was covered with a dressing and stated that the catheter port under the dressing was her access site for dialysis. The resident then showed the surveyor her right forearm and stated that the shunt on her right forearm was an old access site that no longer functions and it is not used for her dialysis. Record review revealed a physician's order, dated 3/1/16, that read, "Dialysis: M-W-F" An undated Dialysis Care Plan read, "Location of Shunt: Right Arm," with no mention of the chest port. The Treatment Administration History for June 2016 contained entries that directed staff to check the bruit/thrill and monitor for bleeding at the fistula site every shift, with no entry for	F 309	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to particopate in the Medicare and Medical	

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F 309	Continued From page 10 monitoring the port site. The Medication Flowsheet contained an entry that read, "Monitor access site for redness bleeding or swelling tid [three times daily] [sic]," with no further explanation of the location of the access site. The current care plan for R19, dated 5/31/16, contained a problem that read, "Resident receives hemodialysis 3 times weekly..." The approaches for this problem included checking bruit/thrill at shunt site, managing bleeding at shunt site, and observing the access site for infection, with no direction as to the location of the access site. One approach read, "No B/P [blood pressure] on RIGHT arm." When interviewed on 6/30/16, at 11:40 a.m., registered nurse (RN)-A was asked the location of the dialysis access site for R19 and he replied that he was not sure, but that information would be in the resident's dialysis binder. The dialysis binder was reviewed and did not contain identification or location of the dialysis chest port. During interview, on 6/30/16 at 11:51 a.m., nursing assistant (NA)-C was asked the location of R19's dialysis access site and replied that she was not sure but she believed R19 had a shunt on her right arm. RN-A was interviewed again on 6/30/16 at 2:18 p.m., and asked if there was any other 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 dialysis access site.	F 309	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. R19 plan of care has been revised to include resident's specific dialysis access site in use, monitoring orders, nursing assistant care guide and nurses communication sheet. A dialysis checklist for admissions has been revised to include specific dialysis site, placing an order to monitor specific site for bruit/thrill, bleeding, redness or swelling and other treatment orders necessary. Currently there are no other residents receiving dialysis. The revised checklist will be used for all future residents on dialysis. The nurses will be educated on the revisions to the policy by August 4, 2016. This plan of correction is integrated into our quality improvement process. The checklist will serve as our audit tool and the clinical managers will complete weekly audits on residents receiving dialysis for four weeks and as deemed necessary by quality committee. Analysis of the observations and facility compliance will be presented to our quality improvement team and approved by the Administrator. 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 this plan of correction.	

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F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative nursing services to maintain or improve walking ability following discharge from physical therapy, for 1 of 1 residents (R41) reviewed for walking. Findings include: Review of the most recent minimum data set ([MDS) quarterly assessment, dated 5/20/16, revealed R41 was cognitively intact. The MDS revealed R41 required one person physical assistance to walk on corridor. The self performance level could not be determined as R41 walked only once or twice during the assessment reference period (7 days). On 6/27/16 at 5:58 p.m., R41 reported he was supposed to be assisted with walking at least daily, but recalled being assisted with walking only six times in the last three months. On 6/29/16 at 8:53 a.m., R41's nursing assistant, (NA)-D, reported she was not currently assisting R41 with a walking program. On 6/29/16 at 9:31 a.m., R41's floor nurse, (LPN)-A reported R41 did a walking program with the restorative nursing assistant. LPN-A reported the restorative nursing assistant documented it	F 311	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to 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	8/4/16

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F 311	Continued From page 12 and she was not responsible for monitoring the completion of daily walking for R41. On 6/29/16 at 10:55 a.m., the clinical nurse manager, (RN)-A, reported he monitored R41's walking program "by exception" noting that R41 had not complained to him about the walking program. RN-A reported his role was to put directions to offer R41 to walk with stand by assistance on the nursing assistants care sheet. After that, the nursing assistants were responsible for the walking program. RN-A reported if the point of care documentation indicated the walking was not completed, it was not completed. There was no way to know if it was offered and refused or not offered. There was no monitoring of distance walked, just if walking occurred or not. RN-A reported the restorative nursing assistant was responsible for the walking program. On 6/29/16 at 11:05 a.m., the restorative nursing assistant, (NA)-E, reported she was not responsible for assisting R41 with a walking program. NA-E reported when R41 discharged from physical therapy, he was assigned to be assisted to walk by his floor nursing assistant, not restorative nursing because he was an "easy walk" On 6/29/16 at 11:18 a.m., NA-D reported she did not walk R41 very often except from chair to bed in his room. Otherwise she was not offering him to walk. NA-D reported she thought NA-A was walking R41. On 6/29/16 at 12:25 p.m., R41's physical therapist, (PT)-A, reported R41 discharged with a	F 311	considered or construed as agreement with the allegations of non- compliance or admission by the Facility. R41 was admitted on 11/15/15 with a diagnosis of MI, Atrial Fib. and obesity and received therapy services through 2/29/16 with documentation of frequent refusals during that timeframe. The plan of care has been revised to include an ambulation program with current results indicating resident averaging daily walks up to 300 feet with good tolerance. The goal is to walk twice a day. Nursing assistant plan of care has been updated and nursing assistants have been trained by restorative aide on resident's ambulation program. Clinical Managers will review the care plans and documentation of the residents on ambulation programs to assure accurate completion of the program. The care plans are reviewed quarterly by 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 with program specifics, create plan of care for ambulation program, revise the nursing assistant plan of care and provide training as needed. Restorative Aide and Clinical Managers will assure program completion and goal success.	

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F 311	Continued From page 13 recommended restorative nursing program to walk daily. PT-A reported R41 was able to consistently walk 70 feet at discharge with stand by assistance at discharge from physical therapy. On 6/29/16 at 12:35 p.m., the director of rehabilitation reported R41 should be on a walking program with nursing. Physical therapy staff had discharged him and provided instructions to nursing staff on the walking program. On 6/26/16 at 1:06 p.m., per surveyor request, NA-D walked with R41 from his room around the recreation room and back to his room. RN-A accompanied NA-D and R41, rolling R41's wheelchair behind R41. R41 was noted to experience shortness of breath but persisted and completed the entire route. R41 reported he wanted to be walking again to keep his skills and abilities. R41 reported this was only his 7th time walking the halls with nursing staff. RN-A again reported there was no system to monitor progress with R41's restorative nursing program. On 6/29/16 at 1:43 p.m., the director of nursing reported RN-A should be monitoring the progress of R41's walking program on a quarterly basis. Review of R41's care plan, dated 12/11/2015, revealed a problem "Mobility Deficit resident requiring assistance with ADLs [activities of daily living] secondary to NSTEMI [type of heart attack], bradycardia, weakness" with a goal "Resident will be able to ambulate/transfer independently" and an intervention "Provide required assistance, stand-by to extensive, for mobility, while encouraging as much independence as able."	F 311	Audits will be completed on current residents with restorative ambulation programs weekly times four weeks by clinical manager or designee and then as 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 approved by the Administrator. 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 this plan of correction.	

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F 311	Continued From page 14 Review of the Nursing Assistant Care Sheet, undated, directed staff "Offer to ambulate resident AM [morning] and PM [afternoon]: Walker, belt and follow with WC [wheelchair]" A review of R41's PT-Therapist Progress and Discharge Summary, dated 2/29/16, revealed "Recommendations discussed with Patient include Ambulation program, standing program, supervision with all mobility" and "patient ambulates 70 feet with stand by assist and 4 wheeled walker with verbal instruction/cues in order to complete functional mobility" Review of Point of Care History revealed how many times R41 walked each month following discharge from physical therapy on 2/29/16. In March 2016, R41 was assisted to walk in corridor at least once on 21 days out of 31 days. In April 2016, R41 was assisted to walk in corridor at least once on 10 days out of 30 days. In May 2016, R41 was assisted to walk in corridor at least once on 4 days out of 31. In June (6/1/16 to 6/30/16) R41 was assisted to walk in corridor at least once on 5 days out of 30. Review of Progress notes and Observations, dated 2/29/16 to 6/30/16 revealed no refusals of ambulation program by R41. The documents reveal no review of the restorative nursing program by a licensed nurse or therapist. The BHS Well Interim Program policy, undated, directed staff, "Upon admission/re-admission/significant change in status the resident will be assessed for potential wellness/restorative needs: The licensed nurse will complete the "Clinical Admission Observation"	F 311		

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F 311	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."	F 311		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene during food preparation and 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.	F 371	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited,	7/29/16

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F 371	Continued From page 16 Findings include: On 6/27/16 from noon to 12:55 p.m. the facility main kitchen walk in freezer was observed to have water dripping from the ceiling onto the floor and containers of food. Multiple containers of food were noted to be in wet containers; including 12 boxes of pies, a box of chicken fingers and a container of rolls. Other containers of food were noted to be wet, although it was difficult to read the contents of the box as the freezer was too full of food containers. The freezer was stacked full of food with boxes of food within two inches of the ceiling and rows of food from the walls to the middle of the walk in freezer, making it difficult for persons to walk through freezer without bumping into or brushing against boxes and bags of food. The dietary manager (DM) confirmed findings and reported much of the food had been there since she started several weeks prior to survey and there was no plan to use it. DM reported the freezer should be cleaned and food should not be so close to the ceiling and fire sprinklers. DM reported staff may have left the door to the freezer open, causing the water to drip from the cooling system. No thermometer was in the freezer. During observation of food preparation during main kitchen on 6/27/16 from noon to 12:55 p.m. (Cook)-A was observed to handle raw meat with 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 spice over the raw 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 garbage, then	F 371	and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to 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. Cook A was removed from food preparation and assigned to non food preparation duties on 6/30/16. Walk in freezer was cleaned and all food stored properly by 7/1/16. Culinary staff will be trained on hand washing, proper glove use and food storage practices by the Culinary Supervisor or Director. Audits of food storage areas will be completed to ensure compliance with policies by Culinary Director, Supervisor and Lead and documented five times/week for two weeks, four times	

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F 371	Continued From page 17 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. DM reported this was not acceptable as the spices may then contaminate whatever food they were used 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 food storage policy, undated, directed staff "All food stored in refrigeration units must be stored in a clean, covered container or otherwise suitable protected. Containers should be arranged so that free circulation of air is allowed at all times." The Handwashing policy, undated directed staff "Therefore, any activity, which may contaminate the hands, must but be followed by thorough handwashing."	F 371	/week times one month and three times /week ongoing. Monitoring for proper hand washing and proper glove use will be completed ongoing by Director, Supervisor and Leads. Analysis of the observations and facility compliance will be presented to our quality improvement team and approved by the Administrator. The quality improvement team will implement needed changes and determine the need for ongoing monitoring/ auditing after analysis. The Director of Culinary Services is responsible for this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	**200 EARL STREET SAINT PAUL, MN 55106**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cerenity Care Center Marian was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us	K 000	EPOC	

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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cerenity Care Center Marian is a 5-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type I(332) construction. In 1969 a 2 story addition was constructed above the 3rd story that was determined to be of type I(332) construction. In 2002 a 1 story addition was constructed to the north that was determined to be type I(332) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected, The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 90 beds and had a census of 84 at the time of the survey. A deficiency for K-067 and annual waiver has been written in past surveys, regarding corridors used as a plenum. It has been determined that this facility meets the CMS S&C-06-18 letter from May 26, 2006.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 34 of 90 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0930 and 1230 on 6/29/2016 observations revealed that the following room doors did not positively latch:	K 018	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does	8/9/16

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K 018	Continued From page 3 Rooms 505 and 206B The deficient practice was observed by the Director of Environmental Services (PF).	K 018	not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to 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. Environmental Services Staff (EVS) corrected Rooms 505 and 206B. EVS staff will check all facility doors for proper latching. These checks have been added to the facility preventative maintenance program for ongoing assurance of proper door latching. The Director of EVS will bring results of these checks to the quality improvement team for review. Director of EVS is responsible for this plan of correction.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by:	K 025		7/25/16

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K 025	Continued From page 4 Based on observation and staff interview, the facility failed to maintain smoke barrier walls in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 90 of the 237 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0930 and 1230 on 6/29/2016 observations revealed that smoke barriers had penetrations at the following locations: Above ceiling at the 4 West Wing smoke doors in front of room 406 there is a large 5ftx5ft square hole in the corridor wall that reveals numerous penetrations in the smoke wall in the residents room through the smoke barrier. Above ceiling at the 2 West Wing smoke doors conduit running through the wall in from of room 231. Above the ceiling at the 2 West Wing smoke doors conduit running through the wall in from of room 218 Above the ceiling in 5 West in front of room 520 there are penetrations in the smoke barrier wall. The penetrations will all need to be sealed on both sides of the smoke barrier. The deficient practice was observed by the Director of Environmental Services (PF).	K 025	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to 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. Environmental Services Staff (EVS)corrected the areas cited in four west wing, two west wing and 5 west wing. An exhaustive inspection was completed by EVS staff on all floors assuring smoke barrier walls are intact. Our annual	

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K 025	Continued From page 5	K 025	preventative maintenance program includes the inspection of all smoke barrier walls too assure proper caulking as needed. EVS Director is responsible for compliance of this plan of correction.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all patients. Findings include: On facility tour between 0930 and 1230 on 06/29/2016, observation revealed that 7 sprinkler heads in the dishwasher room were severely corroded. This deficient practice was verified by the Director of Environmental Services (PF)	K 062	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in thie Credible Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingy, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten(10) calendar days of receipt of the Statement of Deficincies as a condition to	8/9/16

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K 062	Continued From page 6	K 062	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 sprinkler heads.	

MDH
Minnesota
Department
of Health

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00354	A. BUILDING: _____ B. WING _____	06/30/2016

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 27th, 28th, 29th and 30th 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility did not accurately identify the dialysis access site in the plan of care for 1 of 1 resident (R19) reviewed for dialysis. Findings include: During observation in R19's room on 6/30/16, at 10:39 a.m. R19 was asked the location of her dialysis access site. The resident pointed to an area on her upper, left chest area that was covered with a dressing and stated that the catheter port under the dressing was her access site for dialysis. The resident then showed the surveyor her right forearm and stated that the shunt on her right forearm was an old access site that no longer functions and it is not used for her	2 560	Corrected	7/21/16

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2 560	Continued From page 3 dialysis. Record review revealed a physician's order, dated 3/1/16, that read, "Dialysis: M-W-F" An undated Dialysis Care Plan read, "Location of Shunt: Right Arm," with no mention of the chest port. The Treatment Administration History for June 2016 contained entries that directed staff to check the bruit/thrill and monitor for bleeding at the fistula site every shift, with no entry for monitoring the port site. The Medication Flowsheet contained an entry that read, "Monitor access site for redness bleeding or swelling tid [three times daily] [sic]," with no further explanation of the location of the access site. The current care plan for R19, dated 5/31/16, contained a problem that read, "Resident receives hemodialysis 3 times weekly..." The approaches for this problem included checking bruit/thrill at shunt site, managing bleeding at shunt site, and observing the access site for infection, with no direction as to the location of the access site. One approach read, "No B/P [blood pressure] on RIGHT arm." When interviewed on 6/30/16, at 11:40 a.m. registered nurse (RN)-A was asked the location of the dialysis access site for R19 and he replied that he was not sure, but that information would be in the resident's dialysis binder. The dialysis binder was reviewed and did not contain identification or location of the dialysis chest port. During interview, on 6/30/16 at 11:51 a.m., nursing assistant (NA)-C was asked the location of R19's dialysis access site and replied that she was not sure but she believed R19 had a shunt on her right arm. RN-A was interviewed again on 6/30/16 at 2:18 p.m. and asked if there was any other documentation of the dialysis access site for R19, and he replied that he was not aware of any other	2 560		

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2 560	Continued From page 4 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 dialysis access site. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to developing a comprehensive care plan . The DON or designee, could provide training for all nursing staff . The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan for restorative nursing services was followed for 1 of 1 residents (R41) reviewed for ambulation. Findings include: Review of R41's care plan, dated 12/11/2015, revealed a problem "Mobility Deficit resident requiring assistance with ADLs [activities of daily living] secondary to NSTEMI [type of heart	2 565	Corrected	7/21/16

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2 565	Continued From page 5	2 565		

attack], bradycardia, weakness" with a goal "Resident will be able to ambulate/transfer independently" and an intervention "Provide required assistance, stand-by to extensive, for mobility, while encouraging as much independence as able."

Review of the Nursing Assistant Care Sheet, undated, directed staff "Offer to ambulate resident AM [morning] and PM [afternoon]: Walker, belt and follow with WC [wheelchair]"

On 6/27/16 at 5:58 p.m., R41 reported he was supposed to be assisted by nursing staff with walking at least daily, but reported that was not happening on a regular basis.

On 6/29/16 at 8:53 a.m., R41's nursing assistant, (NA)-D, reported she was not currently doing a walking program with R41. On 6/29/16 at 11:18 a.m. NA-D reported she did not walk R41 very often except from chair to bed in his room. Otherwise she was not offering him to walk. NA-D reported she thought NA-A was walking R41.

On 6/29/16 at 10:55 a.m., the clinical nurse manager, (RN)-A reported if the point of care documentation indicated the walking was not completed, it was not completed. There was no way to know if it was offered and refused or not offered.

On 6/29/16 at 11:05 a.m., the restorative nursing assistant, (NA)-E, reported she was not responsible for walking R41. NA-E reported when R41 discharged from physical therapy, he was assigned to be walked by his floor nursing assistant, not restorative because he was an "easy walk"

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2 565	Continued From page 6 On 6/26/16 at 1:06 p.m., per surveyor request, NA-D walked with R41 from his room around the recreation room and back to his room. RN-A accompanied NA-D and R41, rolling R41's wheelchair behind R41. R41 was noted to experience shortness of breath but persisted and completed the entire route. R41 reported he wanted to be walking again to keep his abilities and skills up. R41 reported this was only his 7th time walking the halls with nursing staff. Review of Point of Care History revealed how many times R41 walked each month following discharge from physical therapy on 2/29/16. In March 2016, R41 was assisted to walk in corridor at least once on 21 days out of 31 days. In April 2016, R41 was assisted to walk in corridor at least once on 10 days out of 30 days. In May 2016, R41 was assisted to walk in corridor at least once on 4 days out of 31 days. In June (6/1/16 to 6/30/16) R41 was assisted to walk in corridor at least once on 5 days out of 30. Review of Progress notes and Observations, dated 2/29/16 to 6/30/16 revealed no concerns related to R41 refusing the walking program. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility did not accurately identify the dialysis access site in the plan of care for 1 of 1 resident (R19) reviewed for dialysis. Findings include: During observation in R19's room on 6/30/16, at 10:39 a.m. R19 was asked the location of her dialysis access site. The resident pointed to an area on her upper, left chest area that was covered with a dressing and stated that the catheter port under the dressing was her access site for dialysis. The resident then showed the surveyor her right forearm and stated that the shunt on her right forearm was an old access site that no longer functions and it is not used for her dialysis. Record review revealed a physician's order,	2 830	Corrected	7/21/16

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2 830	Continued From page 8 dated 3/1/16, that read, "Dialysis: M-W-F" An undated Dialysis Care Plan read, "Location of Shunt: Right Arm," with no mention of the chest port. The Treatment Administration History for June 2016 contained entries that directed staff to check the bruit/thrill and monitor for bleeding at the fistula site every shift, with no entry for monitoring the port site. The Medication Flowsheet contained an entry that read, "Monitor access site for redness bleeding or swelling tid [three times daily] [sic]," with no further explanation of the location of the access site. The current care plan for R19, dated 5/31/16, contained a problem that read, "Resident receives hemodialysis 3 times weekly..." The approaches for this problem included checking bruit/thrill at shunt site, managing bleeding at shunt site, and observing the access site for infection, with no direction as to the location of the access site. One approach read, "No B/P [blood pressure] on RIGHT arm." When interviewed on 6/30/16, at 11:40 a.m., registered nurse (RN)-A was asked the location of the dialysis access site for R19 and he replied that he was not sure, but that information would be in the resident's dialysis binder. The dialysis binder was reviewed and did not contain identification or location of the dialysis chest port. During interview, on 6/30/16 at 11:51 a.m., nursing assistant (NA)-C was asked the location of R19's dialysis access site and replied that she was not sure but she believed R19 had a shunt on her right arm. RN-A was interviewed again on 6/30/16 at 2:18 p.m., and asked if there was any other 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	2 830		

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2 830	Continued From page 9 dialysis access site. SUGGESTED METHOD OF CORRECTION: The director of nurses could educate staff on the current dialysis policies and procedures of proper assessment and timely interventions related to dialysis access site. An audit could be completed to ensure compliance and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative	2 915	Corrected	7/21/16

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2 915	Continued From page 10 nursing services to maintain or improve walking ability following discharge from physical therapy, for 1 of 1 residents (R41) reviewed for walking. Findings include: Review of the most recent minimum data set ([MDS) quarterly assessment, dated 5/20/16, revealed R41 was cognitively intact. The MDS revealed R41 required one person physical assistance to walk on corridor. The self performance level could not be determined as R41 walked only once or twice during the assessment reference period (7 days). On 6/27/16 at 5:58 p.m., R41 reported he was supposed to be assisted with walking at least daily, but recalled being assisted with walking only six times in the last three months. On 6/29/16 at 8:53 a.m., R41's nursing assistant, (NA)-D, reported she was not currently assisting R41 with a walking program. On 6/29/16 at 9:31 a.m., R41's floor nurse, (LPN)-A reported R41 did a walking program with the restorative nursing assistant. LPN-A reported the restorative nursing assistant documented it and she was not responsible for monitoring the completion of daily walking for R41. On 6/29/16 at 10:55 a.m., the clinical nurse manager, (RN)-A, reported he monitored R41's walking program "by exception" noting that R41 had not complained to him about the walking program. RN-A reported his role was to put directions to offer R41 to walk with stand by assistance on the nursing assistants care sheet. After that, the nursing assistants were	2 915		

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2 915	Continued From page 11	2 915		

responsible for the walking program. RN-A reported if the point of care documentation indicated the walking was not completed, it was not completed. There was no way to know if it was offered and refused or not offered. There was no monitoring of distance walked, just if walking occurred or not. RN-A reported the restorative nursing assistant was responsible for the walking program.

On 6/29/16 at 11:05 a.m., the restorative nursing assistant, (NA)-E, reported she was not responsible for assisting R41 with a walking program. NA-E reported when R41 discharged from physical therapy, he was assigned to be assisted to walk by his floor nursing assistant, not restorative nursing because he was an "easy walk"

On 6/29/16 at 11:18 a.m., NA-D reported she did not walk R41 very often except from chair to bed in his room. Otherwise she was not offering him to walk. NA-D reported she thought NA-A was walking R41.

On 6/29/16 at 12:25 p.m., R41's physical therapist, (PT)-A, reported R41 discharged with a recommended restorative nursing program to walk daily. PT-A reported R41 was able to consistently walk 70 feet at discharge with stand by assistance at discharge from physical therapy.

On 6/29/16 at 12:35 p.m., the director of rehabilitation reported R41 should be on a walking program with nursing. Physical therapy staff had discharged him and provided instructions to nursing staff on the walking program.

On 6/26/16 at 1:06 p.m., per surveyor request,

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2 915	Continued From page 12 NA-D walked with R41 from his room around the recreation room and back to his room. RN-A accompanied NA-D and R41, rolling R41's wheelchair behind R41. R41 was noted to experience shortness of breath but persisted and completed the entire route. R41 reported he wanted to be walking again to keep his skills and abilities. R41 reported this was only his 7th time walking the halls with nursing staff. RN-A again reported there was no system to monitor progress with R41's restorative nursing program. On 6/29/16 at 1:43 p.m., the director of nursing reported RN-A should be monitoring the progress of R41's walking program on a quarterly basis. Review of R41's care plan, dated 12/11/2015, revealed a problem "Mobility Deficit resident requiring assistance with ADLs [activities of daily living] secondary to NSTEMI [type of heart attack], bradycardia, weakness" with a goal "Resident will be able to ambulate/transfer independently" and an intervention "Provide required assistance, stand-by to extensive, for mobility, while encouraging as much independence as able." Review of the Nursing Assistant Care Sheet, undated, directed staff "Offer to ambulate resident AM [morning] and PM [afternoon]: Walker, belt and follow with WC [wheelchair]" A review of R41's PT-Therapist Progress and Discharge Summary, dated 2/29/16, revealed "Recommendations discussed with Patient include Ambulation program, standing program, supervision with all mobility" and "patient ambulates 70 feet with stand by assist and 4 wheeled walker with verbal instruction/cues in order to complete functional mobility"	2 915		

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2 915	Continued From page 13 Review of Point of Care History revealed how many times R41 walked each month following discharge from physical therapy on 2/29/16. In March 2016, R41 was assisted to walk in corridor at least once on 21 days out of 31 days. In April 2016, R41 was assisted to walk in corridor at least once on 10 days out of 30 days. In May 2016, R41 was assisted to walk in corridor at least once on 4 days out of 31. In June (6/1/16 to 6/30/16) R41 was assisted to walk in corridor at least once on 5 days out of 30. Review of Progress notes and Observations, dated 2/29/16 to 6/30/16 revealed no refusals of ambulation program by R41. The documents reveal no review of the restorative nursing program by a licensed nurse or therapist. The BHS Well Interim Program policy, undated, directed staff, "Upon admission/re-admission/significant change in status the resident will be assessed for potential wellness/restorative needs: The licensed nurse will complete the "Clinical Admission Observation" 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."	2 915		

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2 915	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the resident is ambulated according to the rehabilitation plan The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing ambulation as directed . TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dietary staff consistently followed appropriate hand hygiene in the kitchen. This had the potential to affect all 82 residents receiving food from the dietary department. During observation of food preparation during main kitchen on 6/27/16 from noon to 12:55 p.m., Cook-A was observed to handle raw meat with	21000	Corrected	7/21/16

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21000	Continued From page 15 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 activity, which may contaminate the hands, must but be followed by thorough handwashing." SUGGESTED METHOD OF CORRECTION: The dietary manager and/or designee could develop, review or revise policies, and provide education for staff regarding regarding appropriate hand hygiene in the kitchen. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance TIME PERIOD FOR CORRECTION: Twenty-one	21000		

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21000	Continued From page 16 (21) days.	21000		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. 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. Findings include: On 6/27/16 from noon to 12:55 p.m. the facility main kitchen walk in freezer was observed to have water dripping from the ceiling onto the floor and containers of food. Multiple containers of food were noted to be in wet containers; including 12 boxes of pies, a box of chicken fingers and a container of rolls. Other containers of food were noted to be wet, although it was difficult to read the contents of the box as the freezer was too full of food containers. The freezer was stacked full of food with boxes of food within two inches of the ceiling and rows of food from the walls to the middle of the walk in freezer, making it difficult for persons to walk through freezer without bumping into or brushing against boxes and bags of food. The dietary manager (DM) confirmed findings and reported much of the food had been there since she started several weeks prior to survey	21100	Corrected	7/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00354	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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21100	Continued From page 17 and there was no plan to use it. DM reported the freezer should be cleaned and food should not be so close to the ceiling and fire sprinklers. DM reported staff may have left the door to the freezer open, causing the water to drip from the cooling system. No thermometer was in the freezer. The food storage policy, undated, directed staff "All food stored in refrigeration units must be stored in a clean, covered container or otherwise suitable protected. Containers should be arranged so that free circulation of air is allowed at all times." SUGGESTED METHOD FOR CORRECTION: The dietary director could review and revise policies related to storage and thawing of food in areas of potential contamination. The dietary director could provide education to all dietary staff and monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21100		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students,	21426		7/21/16

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21426	Continued From page 18 residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document complete results of the tuberculosis skin test (TST) that was given for 5 of 5 residents (R16, R19, R114, R121, R138) reviewed for TB screening. The facility failed to ensure completion of Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents for 1 of 5 residents (R138). Findings include: R16 was admitted to the facility on 1/12/16. R16's immunization record did not indicate dates when the first and second step TST were given. Progress note dated 1/15/16, indicated "Mantoux is read today @ no induration; face sheet updated." In addition, 2nd step TST dated 1/25/16, did not indicate negative results. R19 was admitted to the facility on 2/19/16. R19's immunization record did not indicate dates when the first and second step TST were given. Progress note dated 3/4/16, indicated "2nd Mantoux 0 mm induration." In addition, 1st and 2nd step TST did not indicate negative results.	21426	Corrected	

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21426	Continued From page 19 R114 was admitted to the facility on 3/10/16. R114's immunization record did not indicate date when the first TST or second step TST was given. The 1st step TST reading dated 3/13/16, did not indicate negative results. R121 was admitted to the facility on 3/17/16 R121's immunization record did not indicate dates when the first and second step TST were given. R138 was admitted to the facility on 1/18/16. R138's immunization record did not indicate dates when the first and second step TST were given. Progress note dated 1/21/16, indicated "1st step Mantoux read on RFA 0mm." Progress note dated 1/31/16, indicated "2nd step mantoux read on LFA, 0mm, updated on face sheet." The Baseline TB Screening was not completed. In addition, 1st and 2nd step TST did not indicate negative results. On 6/30/16, at 3:19 p.m. director of nursing (DON) verified R114 did not have a second TST and would follow-up on it. On 6/30/16, at 3:47 p.m. DON stated her expectation was TST documentation included date month year, mm induration and a positive or negative reading. She indicated the facility followed the Minnesota Department of Health (MDH) guidelines. The MDH policy provided dated July 2013 indicated "each facility should have written procedures to address TB infection control ... TST documentation for residents should include the date (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative)... Baseline TB Screening Tool for Residents Template indicated "TST-First	21426		

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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.	21426		