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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MF9T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00923

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

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

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

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

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

6. DATE OF SURVEY **11/04/2021** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
08/31

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Documentation supporting the facility's request for a temporary waiver involving K133 has been forwarded to CMS on 11/22/21.

17. SURVEYOR SIGNATURE — Date :
Sarah Grebenc, Unit Supervisor — 01/05/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 01/05/2022 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
06201 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
11/29/2021 (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 5, 2022

CMS Certification Number (CCN): 245300

Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

Dear Administrator:

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

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

Effective November 25, 2021 the above facility is certified for:

138 Skilled Nursing Facility/Nursing Facility Beds

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

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K-133.

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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
January 5, 2022

Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: CCN: 245300
Cycle Start Date: September 23, 2021

Dear Administrator:

On October 19, 2021, we notified you a remedy was imposed. On December 7, 2021 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 25, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 3, 2021 be discontinued as of November 25, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 19, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 4, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Correction of the Life Safety Code deficiency(ies) cited under K-133 at the time of the September 22, 2021 standard survey, has not yet been verified. Your plan of correction for this deficiency / these deficiencies, including your request for a temporary waiver with a date of completion of April 22, 2022, has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency / these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MF9T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00923

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

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

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

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

6. DATE OF SURVEY **09/23/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
08/31

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

12.Total Facility Beds **138** (L18)
13.Total Certified Beds **138** (L17)

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

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

* Code: **B***, 5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Documentation supporting the facility's request for a temporary waiver involving K133 has been forwarded to CMS on 11/22/21.

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 11/22/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/29/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 19, 2021

Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: CCN: 245300
Cycle Start Date: September 23, 2021

Dear Administrator:

On September 23, 2021, a 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 3, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 3, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 3, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 3, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cerenity Care Center - White Bear Lake will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 3, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 23, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals

Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification and Complaint Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health on 09/20/21 through 09/23/21. The facility was found to be in compliance with 42 CFR 483.73. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/20/21 through 9/23/21, a standard recertification survey and complaint surveys were conducted at your facility by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5300058C (MN61382) with deficiency cited at F919 H5300060C (MN66659) with deficiency cited at F689 H5300061C (MN65829) with deficiency cited at F689 and F919 H5300062C (MN54818) with deficiency cited at F919 and F550 H5300064C (MN60091) with deficiency cited at F689 H5300066C (MN65685) with deficiency cited at F689	F 000		

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

Electronically Signed | 10/29/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 H5300067C (MN59428) with deficiency cited at F689 The following complaints were found to be UNSUBSTANTIATED: H5300057C (MN55815) H5300059C (MN66663) H5300063C (MN55816) H5300065C (MN65831) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and documentation, the facility failed to protect the dignity for four of four residents (R23, R80, and R96, and R103) sampled for dignity concerns by ensuring their personal privacy. The failures created the potential that these residents would experience feelings of unworthiness or embarrassment. Findings include:	F 550	The facility policies 'Resident Rights and Notification of Resident Rights' and Prevention of CAUTI and Collection Device Infections' were reviewed and updated. R 80's catheter was discontinued on 9/24/21. R 96 and R 103 had catheter covers placed over their urinary collection bags. All other residents with catheters also had a cover placed over their urinary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 1. Review of R80's significant change of condition (SCOC) Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/27/21, revealed R80 was admitted to the facility on 8/3/21; she had a Brief Interview of Mental Status (BIMS) score of 15, indicating she was cognitively intact; and she had an indwelling urinary catheter. During an observation of R80 on 9/20/21, at 12:17 p.m. revealed R80 was in her wheelchair in the hallway near the nurse's station on the first floor Transitional Care Unit (TCU), along with a visitor. The resident's urinary catheter drain bag was visible under the seat of her wheelchair, not enclosed in a privacy cover. The drain bag was approximately one third full of urine. In an interview with R80 on 9/21/21, at 4:07 p.m., R80 stated she knew her catheter drain bag was kept under her wheelchair seat but was not sure whether it was enclosed in a privacy bag or not. When asked, R80 stated she presumed the positioning of the bag under her wheelchair seat prevented others from being able to see it. R80 stated, "I definitely don't like the idea of other people looking at my urine." 2. Review of R96's SCOC MDS assessment, with an ARD of 9/7/21, revealed he was admitted to the facility on 8/16/21; had a BIMS of 14, indicating he was cognitively intact; and required an indwelling urinary catheter. During an observation of R96 on 9/20/21 at 1:47 p.m. revealed R96 was sitting in his room in his wheelchair. His urinary catheter drain bag was visible under the seat of the wheelchair, with no	F 550	collection bags. All residents with catheters had nursing orders put in for nurses and CNAs to document compliance and verify catheter covers are in placed, catheter bags and tubing are not exposed and tubing is not on the ground. NAR care guides were updated to add catheter bag covers for those with catheters. Care plans of residents with catheters were updated to include catheter bag covers and keep tubing off the ground. NA-26 was educated that residents being transported to/from the shower room for bathing need to have skin covered with clothing or a blanket so no exposed skin is visible. Nursing staff will be educated on privacy and dignity with resident bathing and ensuring the resident is covered thoroughly before and after shower care. Nursing staff will also be educated on use of urinary collection bag covers, the importance of keeping catheter tubing off the ground, and keeping the collection bag and tubing covered for privacy and dignity. DON or designee will ensure and monitor compliance. Audits of urinary collection bag covers, catheter tubing remaining off the ground, and residents being covered thoroughly during transport to/from the shower room will occur two times per week for two weeks, weekly for 2 weeks, and then three times per month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 privacy cover. The bag was approximately one quarter full of urine. Registered nurse (RN)-24 entered the room to adjust R96's wound vac, which caused him to squat down behind R96's wheelchair and look under the seat. RN-24 stated nothing was wrong with R96's catheter drain bag, and it was exposed per norm to allow staff to visualize the characteristics of the urine. R96 stated it was not his preference that others were able to see his urine. 3. Review of R23's quarterly MDS assessment, with an ARD of 6/30/21, revealed she was admitted to the facility on 4/16/20; had a BIMS of 15, indicating she was cognitively intact; she required extensive assistance of one person for transfers; she did not ambulate; and she required physical assistance from one person to bathe. During an observation of R23 on 9/21/21 at 09:01 a.m. revealed nursing assistant (NA)-26 was bringing R23 out of her room in a white plastic shower chair. R23 was wearing a hospital gown draped over the front of her body, which was also covered by a blanket and a sheet. From the side of the chair, R23's bare thighs and buttocks were visible as she was propelled through the hallway. An interview with NA-26 at that time revealed she thought she had covered R23 sufficiently to take her to the shower and did not realize her thighs and buttocks were visible. R23 stated she did not realize her buttocks and thighs were visible and would not want others to see them. An interview with the director of nursing (DON) on 9/21/21, at 3:17 p.m. revealed it was her expectation that catheter drain bags were enclosed in a privacy bag, and that R23's thighs and buttocks should have been covered as she	F 550	/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

was taken to the shower. The DON stated the facility did not have specific policies that covered these expectations, but it was a resident's right to be treated with dignity and respect, which would include placing urinary drain bags in privacy covers and covering residents as they were transported to the shower room.

An interview with the administrator on 9/23/21, at 4:26 p.m. revealed it was his expectation that residents were treated with dignity, which included placing urinary catheter drain bags in privacy covers and covering residents as they were transported to the shower room.

4. Review of R103's admission MDS assessment, with an ARD of 9/8/21, revealed he scored a 15 on the BIMS, indicating intact cognition. R103 required extensive assistance by staff for mobility and used an indwelling urinary catheter.

During an observation on 9/20/21, at 9:48 a.m. revealed R103 was sitting in his room in a chair at the foot of his bed. The door to the room was open and R103 was viewable by anyone in the hall. R103's catheter drain bag was fully uncovered and on the floor.

During an interview with NA-7 on 9/20/21, at 9:50 a.m. revealed catheter bags should be covered and always off the floor.

Further observation on 9/22/21, at 8:25 a.m. revealed R103 was sitting in his room in a chair at the foot of his bed. The door to the room was open and R103 was viewable by anyone in the hall. R103's catheter bag was fully uncovered and on the floor. R103 did not have any input into the placement of his catheter drainage bag when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6 interviewed. During an interview with registered nurse (RN)-3 on 9/22/21, at 8:27 a.m. revealed R103's catheter drain bag should be covered and the bag should never be on the floor.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 7 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interviews and documentation, the facility failed to ensure three resident (R80, R47, and R53) of 26 Initial Pool residents had the opportunity to formulate an advanced directive. This failure placed these three residents at risk of not having their wishes followed if they were no longer able to communicate on their own behalf. Findings include: 1. Review of R80's significant change of condition (SCOC) Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/27/21, revealed R80 was admitted to the facility on 8/3/21, and had a Brief Interview of Mental Status (BIMS) score of 15, indicating she was cognitively intact. In an interview with R80 on 9/21/21, at 4:07 p.m., R80 stated she could not remember if the facility had asked her about advanced directives, but she had developed one and felt it was important that the facility know her wishes. Review of R80's physician's orders, located under the Orders tab of her Electronic Medical Record (EMR), revealed a full code (full resuscitation)	F 578	The facility policy 'Advanced Directives' was reviewed and remains appropriate. R 80 was interviewed on 9/22/21 and verified she does have a HCD, message left with son to request a copy of the record. Son did not bring this to the facility and another call was again made to him on 10/26/21 to request a copy of the HCD. Will continue to request a copy until received. R 47 had an Advanced Directive-Short Form completed on 9/22/21 and is now in the medical record. R53 has since discharged the facility but did have an Advanced Directive-Short Form completed on 9/22/21 and was placed into her medical record. A chart audit was completed for all TCU patients to verify that a HCD is on file and if not, options and assistance of completing a HCD have been offered and documented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 8 status. Continued review of R80's EMR revealed no further advanced directives on file. Review of R80's Nursing Progress Notes, located under the Progress Notes tab of her EMR, revealed an admission nursing assessment on 8/24/21, at 4:28 a.m. wherein R80 stated to the nurse that she had an Advanced Directive, but did not bring a copy to the facility with her. In an interview with the social services director (SSD) on 9/22/21, at 2:03 p.m., the SSD stated if a resident had an advanced directive prior to admission to the facility, there was not a process by which the facility would try to obtain a copy of it. The SSD stated, "We don't hassle people on the TCU (Transitional Care Unit, where R80 resided). We ask and then it's up to them to follow up. We can assist with advanced care planning if they want, but we don't hassle them about it." 2. Review of R47's admission MDS assessment, with an ARD of 8/7/21, revealed she was admitted to the facility on 7/31/21, and had a BIMS score of 13, indicating she was cognitively intact. Review of R47's physician's orders, located under the Orders tab of her EMR, revealed a full code resuscitation status. Further review of her EMR revealed no other advanced directives on file. In an interview with R47 on 9/21/21, at 8:36 a.m., R47 stated she did not have an advanced directive and did not remember the facility asking her about it. R47 stated she would like more information on how to formulate one.	F 578	Social Service education was completed to ensure advanced directives are discussed upon admission, options for completion are discussed and followed up on, and a copy of the current HCD is requested from patient/family and added to the patient's medical record. SSD or designee will monitor compliance. Chart audits will be completed weekly for 4 weeks, then bi-monthly for 8 weeks, or until next quality meeting to assure compliance in this area. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring /auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 9	F 578		

In an interview with the SSD on 9/22/21, at 2:03 p.m., the SSD stated R47 was provided with a packet explaining advanced directives at the time of her admission, and it was up to her to follow up with the facility if she wanted to pursue it.

3. Review of R53's Admission MDS assessment, with an ARD of 8/12/21, revealed she was admitted to the facility on 8/5/21, and had a BIMS score of 13, indicating she was cognitively intact.

Review of R53's physician's orders, located under the Orders tab of her EMR, revealed a full code resuscitation status. Further review of her record revealed no other advanced directives on file.

In an interview with R53 on 9/20/21, at 11:45 a.m., R53 stated she had not thought about advanced directives prior to the COVID-19 pandemic, but then contracted COVID-19 and ended up in the hospital for months. R53 stated during her hospitalization she ended up in the intensive care unit on a ventilator, placing her son in the position of making health care decisions for her. R53 stated she could not remember if the facility had asked about advanced directives since her admission to the facility, but it was something she would like to learn more about.

In an interview with the SSD on 9/22/21, at 2:03 p.m., the SSD stated R53 was provided with a packet explaining advanced directives at the time of her admission, and it was up to her to follow up with the facility if she wanted to pursue it.

An interview with the administrator on 9/23/21, at 4:36 p.m. revealed it was his expectation the facility would meet the regulatory requirement for assisting residents to obtain or formulate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 10 advanced directives. Review of the facility's undated Advanced Directives policy revealed, Admitted residents will receive introductory information describing Advance Care Planning, including how to formulate an Advance Directive (Advance Directive: Short Form) - this is provided in the admission packet and will be followed up by the Social Worker.	F 578		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 11 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation, the facility failed to safeguard personal and medical information of residents when personal and medical information, were left accessible for any staff, visitor, or resident to view. This deficient practice affected 17 residents, (R8, R11, R20, R35, R51, R53, R79, R85, R90, R96, R207, R209, R210, R211, R212, R213, and R307) of 110 residents in the facility. Findings include: During an observation on 9/22/21, at 8:05 a.m. revealed the 2nd Floor Transitional Care Unit (TCU) medication cart was in the hallway unattended. The cart contained an open and unlocked computer monitor on top. No staff was in sight of the computer monitor from 8:05 a.m. to 8:15 a.m. The monitor displayed R307's name, date of birth, physician, allergies, and medication list. Also on the medication cart was a container of Prednisone (a steroid medication) for R213. The medication label contained the R213's name, medication name, and physician. During an interview on 9/22/21, at 8:16 a.m. with clinical manager (CM)-4 revealed the computer monitors were to always be locked due to the Health Insurance Portability and Accountability	F 583	The facility policy 'Introduction to Benedictine Health System HIPAA; was reviewed and remains appropriate. All nursing stations were audited on 10/26/21 to ensure there was no resident HIPAA information visible to others on medication cart computers, that there were no medications left out, and the nursing report sheets and team sheet care plans were stored in the appropriate area. R213 had a SAM completed 9/245/21 for the Prednisolone eye drops identifying she is able to self-administer and now has an order to keep at bedside. Nursing staff will be educated on the HIPAA policy and importance of keeping resident information private and not in areas that can be seen by others. This education will also include minimizing or closing EMARs (medication cart computers) when unattended and keeping all medications stored appropriately. DON or designee will ensure and monitor compliance. Audits of nursing stations for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 12 Act (HIPAA) requirements. The CM stated the medications on the cart should have never been left unattended. During an observation on 9/22/21, at 8:35 a.m. of the Oak Crossing Unit revealed a "Team Sheet Care Plan" on the counter of the nurses' station in the hallway for anyone to view. This sheet contained the names and room numbers for R8, R11, R20, R33, and R51. The sheet also contained information on each resident concerning use of glasses, hearing aids, or dentures; bathing requirements; weight schedules; device usage; safety concerns; range of motion requirements; repositioning requirements; and grooming and hygiene needs. During an observation on 9/22/21, at 7:45 p.m. of the 1st Floor TCU revealed a "Nurse Report Sheet" on top of the medication cart in the hallway. No staff was present at the time of the observation. The "Nurse Report Sheet" contained the names, room numbers, diagnoses, admission dates, physicians, and nurses' notes for R53, R79, R85, R90, R96, R207, R209, R210, R211, and R212. During an interview on 9/22/21, at 7:55 p.m. with CM-5 revealed no documents with any resident information should ever be left uncovered and unattended in a place where others can see it, such as a medication cart. Review of the facility's policy, "POL_HIP001-Introduction to Benedictine Health System Health Insurance Portability and Accountability Act," dated 3/5/14, revealed "BHS and participating organizations will comply with all applicable privacy requirements of HIPAA" and	F 583	HIPAA compliance will occur three times per week for two weeks, weekly for 2 weeks, and then three times per month for 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring /auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 13 explained these requirements included protecting health information that "is created or received by a health care provider; identifies the resident; and relates to past, present, or future physical or mental conditions."	F 583		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation, the facility failed to determine the need for, and provide needed required supervision and/or assistive devices to prevent further falls for two (R219 and R52) of ten residents reviewed for repeated falls in the facility. R219 was harmed when he fell and sustained a laceration to his head and unstable fractures of his cervical spine; R219 was receiving hospice services and passed away two days after this fall. The failure placed R52 at risk for repeated falls. Findings include: FALLS Review of the facility's "Integrated Fall Management" policy, reviewed 5/6/21, revealed, "Residents are assessed for their risk of falls upon admission, significant change, and quarterly thereafter. Residents with risk for falling will have	F 689	The facility policy 'Integrated Fall Management' was reviewed and remains appropriate. R 219 and R 52 no longer reside at the facility. All residents with 3 or more falls in the last quarter had a comprehensive review of fall events completed. Care plan and NAR guides were updated if indicated. Nursing staff will be educated on the Fall Management Program including the post fall huddle checklist. IDT team will be educated on the use of the post fall checklist/huddle tool as a method to review and document contributing factors and identify the root cause of the event. Fall management Program tools have	11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the resident's condition, provides care for safety and comfort . . . Post Fall Procedure . . . The environment of the fall is evaluated for possible contributing factors and addressed . . . The interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions . . . Fall with Significant Injury: A fall with significant injury is a fall that results in a bone fracture, joint dislocation, closed head injury with altered consciousness, subdural hematoma, or death." 1. Review of R219's "Face Sheet," located under the "Face Sheet" tab of his Electronic Medical Record (EMR) revealed he was admitted to the facility on 11/5/19, with diagnoses that included alcoholic cirrhosis of the liver, diabetes mellitus type 2, and chronic kidney disease. Further review of the resident's record revealed he was enrolled in hospice services. Review of R219's 11/12/19, Care Plan, located under the "Care Plan" tab of his EMR, revealed a problem area for risk for falls related to diagnoses of congestive heart failure (CHF), low hemoglobin, morbid obesity, anemia, significant lower extremity edema, a history of falls, occasional incontinence, and the need for hospice services. Interventions included encouraging the resident to use environmental devices such as grab bars, walker, and electric wheelchair; ensuring his call light was in reach; a nonskid mat at bedside; and the use of gripper (nonskid) socks. No new interventions were added to R219's falls "Care Plan" after the resident sustained repeated falls, resulting in a fall with significant injury.	F 689	been placed on each nursing unit in binders. DON or designee will monitor compliance. Audits of compliance with the Fall Management Program components will occur 2x per week x 2 weeks, weekly x 2 weeks, then 3x per month x 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

Review of the paper "Event Reports," provided by the facility, revealed R219 had three falls during his stay in the facility:

a. The 1/10/20, "Event Report" revealed the resident had a fall in his room on 1/10/20, wherein he was found in his room laying on the floor next to the door. Further review of the "Event Report" revealed the resident stated at the time, he had been sitting and had reached for something, causing him to fall. Continued review of the "Event Report" did not reveal what the resident had been reaching for when he fell. An Interdisciplinary Team (IDT) note, dated 1/13/20, and attached to the 1/10/20, "Event Report," revealed R219 agreed to use his reacher device to obtain objects in the future. Review of the resident's "Care Plan" revealed this intervention was not added.

b. The 1/25/20, "Event Report" revealed R219 had a fall in his room on 1/25/20, at 11:00 p.m., wherein he was found sitting on the floor beside his bed. Further review of the "Event Report" revealed no more information about the circumstances surrounding R219's fall. An IDT note, dated 1/27/20, and attached to the 1/25/20, "Event Report," revealed the resident stated he was reading a book while sitting on the edge of his bed, his buttocks started to slide forward, and he was unable to get his legs under himself to stop sliding, so he slid to the floor. Further review of the IDT note revealed the resident had been noted with a low hemoglobin value of 6.1 grams per deciliter (g/dl) on his most recent lab report (normal range for an adult male is 13.5 to 17.5 g/dl), and "did have one other fall from bed where the resident had attempted to sit self on edge of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

bed and was too close and slid to his buttocks." The IDT note concluded that the 1/25/20, fall was an "isolated event," and no new interventions were required to prevent further falls from bed, even though this was a repeat fall from sitting on the edge of the bed. The facility failed to implement appropriate interventions to prevent another fall from the edge of his bed at this time.

c. The 3/23/20, "Event Report" revealed R219 was found on the floor of his room on 3/19/20, at 5:10 p.m., with his head under his electric scooter in a pool of blood. Emergency Medical Services (EMS) were summoned, and the resident was sent to the hospital where he was found to have a laceration to his head requiring 13 sutures, as well as unstable fractures of his cervical spine at vertebrae C5 and C6. Further review of the facility's investigation revealed, "had been observed to fall asleep upright despite continual staff reminders and encouragement to ask for assistance for his safety." Further review of the incident report revealed that after the resident was found on the floor with a head laceration and other injuries, R219 stated that he "must have fallen asleep" while sitting at the edge of his bed.

Review of R219's "Nursing Progress Notes," located under the "Progress Notes" tab of his EMR, revealed that R219 returned to the facility from the hospital on 3/20/20, and passed away on 03/21/20. Thus, no observations could be made for this resident during the survey.

In an interview with the Director of Nursing (DON) on 9/22/21, at 11:48 a.m., the DON stated in general, it was her expectation that after a resident fell, the IDT would conduct a review of the fall the next business day in the morning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

meeting. The DON stated that the IDT should determine the factors leading up to the fall, and review and revise a resident's care plan as appropriate. When asked how the IDT determined how R219's fall from 1/25/21 was "isolated," the DON stated that the determination was made on "historical data and previous falls," but could not elaborate further. The DON stated typical interventions for such a fall would be "frequent checks," although the facility had no specific definition of what constituted "frequent checks," alarms, cushioned floor mats or other padding, or anything listed on the facility's falls policy. The DON stated R219 had valued his independence, so the facility did not necessarily implement any new fall prevention interventions. When asked to provide the investigative documents outlined in the facility's "Integrated Fall Management" policy for R219's falls, the DON stated the facility considered those items "tools" and as such they were not always completed. The DON stated she did not think those tools had been completed for R219, but she would provide them if the facility had them.

In an interview with registered nurse (RN)-4 on 9/22/21, at 3:15 p.m. revealed she was the nurse in charge of the unit where R219 resided. RN-4 stated she recalled R219 and was aware he had fallen while in the facility. Regarding the 1/25/20, fall, RN-4 stated she had determined the incident was isolated given R219's desire for independence. After reviewing the "Event Report" provided by the facility, RN-4 could not determine when R219 had been last seen or assisted by staff prior to the fall. RN-4 stated R219's low hemoglobin level could contribute to increased weakness and/or dizziness, but since the resident was receiving hospice services at the time of this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

fall, she did not consider whether interventions such as increased supervision or encouraging the resident to rest in a comfortable chair or recline in his bed would benefit him. When asked about R219's fall on 3/19/20, at 5:10 p.m., RN-4 stated she could not determine, from looking at the facility's completed investigation, when the resident had last been attended by staff, or what he was doing before being found by staff. RN-4 stated she has not been aware, until reviewing the facility's completed investigation, that staff had known R219 was falling asleep while sitting on the edge of his bed. RN-4 stated, "That's important to know. Had I known that, I definitely would have talked to him about it and encouraged him to sit in a recliner or somewhere other than the edge of his bed."

In an interview with the DON on 9/23/22, at 1:46 p.m., the DON stated the facility had not completed any additional documentation regarding R219's falls.

In an interview with the administrator on 9/23/21, at 3:30 p.m. revealed the facility had identified falls as a Quality Assurance and Performance Improvement (QAPI) project, and it was his expectation the facility would follow the regulatory requirements for fall prevention while respecting resident's choices for independence.

2. Review of R52's "Admission Record," located under the "Face Sheet" tab of the EMR revealed he was admitted to the facility on 5/15/21, with diagnoses including: history of falling, Parkinson's disease, dementia with Lewy bodies, paranoid personality, hallucinations, aftercare joint replacement surgery (left hip), and abnormality with gait and mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

Review of R52's admission "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 5/22/21, revealed a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicating cognitively intact mental status. R52 required assistance by one staff member with mobility and was at risk for falls.

Review of R52's 6/14/21, "Care Plan," located in the EMR under the "Care Plan" tab, revealed the facility recognized the resident was at risk for falling and had a history of falls with physical and cognitive impairments, Parkinson's disease with impaired balance and gait instability, and use of psychotropic medications. The "Care Plan" documented, "Resident attempts to get up unsafely on his own and turns his alarms on and off." The interventions included providing "safety alarms on the bed and chair. Resident has a history of turning off alarms. Staff to check throughout shift to ensure the alarms are on." Additional interventions included: providing an environment free of clutter; keeping personal items and frequently used items within reach of the resident; ensuring the call light was in reach; assuring R52 had proper, well-maintained footwear; and providing verbal reminders not to ambulate or transfer without assistance.

Review of paper "Event Reports" provided by the facility revealed R52 experienced eight falls in the facility between his admission on 5/15/21, and 9/18/21, on: 5/16/21, 5/27/21, 6/6/21, 8/6/21, 8/18/21, 8/29/21, 9/3/21, and 9/18/21.

a. The 5/16/21, "Event Report" revealed R52 fell on 05/16/21, at 9:03 a.m., where he was found crawling on the floor, alarms turned off, and tab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

alarm removed from the resident. Further review of the "Event Report" and R52's EMR revealed no documentation of an IDT discussion on the root cause of the fall or appropriate interventions implemented to address the resident's removal and turning off of the alarms.

During an interview with the DON on 9/23/21, at 1:46 p.m. revealed the facility had not conducted a root cause analysis for this fall and had not developed any new interventions for fall prevention, or to address the resident's removal/disarming of the alarms. The DON confirmed the facility continued to use safety alarms as a fall prevention measure after this fall.

b. The 5/27/21, "Event Report" revealed R52 had an unwitnessed fall on 5/27/21, at 2:11 p.m., where R52 slid out of his wheelchair while attempting to pick up his alarm that had fallen off his shirt. Further review of the "Event Report" and R52's EMR revealed no documentation of an IDT discussion on the root cause of the fall or appropriate interventions implemented to address the resident's removal of the alarms.

During an interview with the DON on 9/23/21, at 1:46 p.m. revealed the facility had not conducted a root cause analysis for this fall and had not developed any new interventions for fall prevention, or to address the resident's removal of the alarms. The DON confirmed the facility continued to use safety alarms as a fall prevention measure after this fall.

c. The 6/6/21, "Event Report" revealed R52 had an unwitnessed fall on 6/6/21, at 1:42 p.m., where R52 fell backward when he lost his balance and knees gave out. No injury was noted. The fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

alarm was sounding. Further review of the "Event Report" and R52's EMR revealed no documentation of an IDT discussion on the root cause of the resident's dizziness and subsequent fall, or appropriate interventions implemented to address the resident's loss of balance.

During an interview with the DON on 9/23/21, at 1:46 p.m. revealed the facility had not conducted a root cause analysis for this fall and had not developed any new interventions for fall prevention. The DON confirmed the facility continued to use safety alarms as a fall prevention measure after this fall.

d. The 8/6/21, "Event Report" revealed R52 had a witnessed fall in the dining room on 8/6/21 at 7:48 p.m. R52 stood up with the alarm sounding and his legs buckled, and he fell along the edge of the table and landed on his right side on the floor. R52 sustained a quarter-size hematoma on his right eyebrow, two abrasions on his right wrist, and two shallow skin cuts on his upper lip. The section of the report to document a pattern to the falls was left blank. Further review of the "Event Report" and R52's EMR revealed no documentation of an IDT discussion on the root cause of the fall or appropriate interventions implemented to prevent recurrence.

During an interview with the DON on 9/23/21, at 1:46 p.m. revealed the facility had not conducted a root cause analysis for this fall and had not developed any new interventions for fall prevention. The DON confirmed the facility continued to use safety alarms as a fall prevention measure after this fall and stressed the importance of remaining seated to R52.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

e. The 8/18/21, "Event Report" revealed R52 had an unwitnessed fall on 8/18/21, at 1:53 p.m., wherein he was found by a visitor sitting on his backside on the floor. R52 stated he was trying to go to the bathroom and slid off his chair. There was no documentation whether the safety alarm was in place or sounding. Further review of the "Event Report" and R52's EMR revealed no documentation of an IDT discussion on the root cause of the fall or appropriate interventions implemented to prevent recurrence.

During an interview with the DON on 9/23/21, at 1:46 p.m. revealed the facility had not conducted a root cause analysis for this fall and had not developed any new interventions for fall prevention. The DON confirmed the facility continued to use safety alarms as a fall prevention measure after this fall.

f. The 8/29/21, "Event Report" revealed R52 had a witnessed fall on 8/29/21, at 4:00 p.m. in the dining room. R52 was seated in his wheelchair and stood up, took two steps, and went down on his right knee. The alarm sounded. Further review of the "Event Report" and R52's EMR revealed no documentation of an IDT discussion on the root cause of the fall or appropriate interventions implemented to prevent recurrence.

During an interview with the DON on 9/23/21, at 1:46 p.m. revealed the facility had not conducted a root cause analysis for this fall and had not developed any new interventions for fall prevention. The DON confirmed the facility continued to use safety alarms as a fall prevention measure after this fall.

g. The 9/3/21, "Event Report" revealed R52 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

an unwitnessed fall on 9/3/21, at 5:45 p.m. in his room. The report documented R52 had tried to get up independently. There was no documentation of whether the alarm was sounding. Further review of the "Event Report" and R52's EMR revealed no documentation of an IDT discussion on the root cause of the fall or appropriate interventions implemented.

Review of R52's "Care Plan" revealed new interventions were implemented on 9/7/21, including: keeping the resident, when awake, in the dayroom or by the nursing unit for close observation; placing R52's at the appropriate height; and encouraging R52 to use the call light for all transfers.

During an interview with the DON on 9/23/21, at 1:46 p.m. revealed the facility had not conducted a root cause analysis for this fall but had developed new interventions to increase supervision of R52 and adjust his bed to an appropriate height. The DON confirmed the facility continued to use safety alarms as a fall prevention measure after this fall.

h. The 9/18/21, "Event Report" revealed R52 had an unwitnessed fall on 9/18/21, at 7:00 p.m. in his room, resulting in a laceration to his left eyebrow with profuse bleeding and blood on the floor. R52 complained of pain to his left eyebrow, lower back, and right hip. The report documented the IDT reviewed the fall on 9/21/21, and had the hospice provider review R52's medication regimen for any changes with medication, resulting in new prescriptions for Ativan (an anti-anxiety medication) and morphine (a pain medication) to decrease restlessness and anxiety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24 During an interview with the DON on 9/23/21, at 1:46 p.m. revealed she was aware R52 would frequently remove/turn off his alarms; however, the facility continued to use alarms as a main intervention for fall prevention. She stated the facility had not done root cause analyses of R52's falls or implemented additional interventions to help prevent falls. The DON added, "We didn't have a good system [for addressing falls], but we have a new [unit] manager . . . and she is much more aggressive on that kind of thing."	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 25 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation, the facility failed to ensure medications were accurately stored in one of four medication carts and one of four medication rooms in accordance with professional standards of practice. One medication was not secured for R213 and stock medications were not discarded when expired. Findings include: During an observation on 9/22/21, at 8:05 a.m., of the 2nd Floor Transitional Care Unit (TCU) medication cart revealed a full container of Prednisone (a steroid medication) on top of the medication cart, which belonged to R213. No staff was in sight of the medication cart from 8:05 a.m. to 8:15 a.m. During an interview on 9/22/21, at 8:16 a.m., clinical manager (CM)-4 revealed the medication on top of the cart should have never been left unattended. During an observation on 9/23/21, at 8:19 a.m. the Cypress Court medication room stock medications revealed one bottle of Vitamin D tablets with an expiration date of April 2021. During an interview on 9/23/21, at 8:25 a.m. with registered nurse (RN)-6 stated she would discard the expired medication. Review of the facility's 2018 policy, "POL_NS702: Administering Medications" revealed, ". . . expired	F 761	The facility policy 'Administering Medications' was reviewed and revised 10/25/21. R 213 was assessed on 9/24/21 for a SAM for the Prednisolone eye drops and found capable to self administer her eye drops and has an order to keep eye drops at the bedside. All resident with eye drops were verified to be secured within the medication cart unless the resident had a SAM completed. RN in charge of R213's care on 9/22/21 was educated on storage of medication and not leaving medications unsupervised. This education occurred on 10/25/21. The expired Vitamin D bottle was removed from Cypress Courts medication room and destroyed per facility policy. All medication rooms were audited the week of October 18th to ensure no expired stock medications were present. Nursing education for licensed nurses and Trained Medication Assistants will be conducted on October 27th and 28th: the Administering Medications policy will be reviewed with emphasis on not having medications on top of the medication cart. The policy additionally addresses checking the expiration dates on all medications prior to administering the medications. DON or designee will monitor compliance. Audits of medication carts to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 26 medications should be disposed of."	F 761	medications are stored properly and audits of medication rooms to ensure no medications are expired and available for use. Audits will occur 3x per week x 2 weeks, weekly x 2 weeks, then 3x per month x2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.	F 803		11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on document and interviews, the facility failed to ensure the menu was followed. Review of the menu and the policy revealed the facility used a five meal per day menu/meal plan; however, they failed to ensure each resident was provide adequate vegetables in accordance with the facility policy and United States Department of Agriculture (USDA) "Food Guide Pyramid." This had the potential to affect all 110 residents in the facility. Findings include: The undated facility policy titled, "Resident Choice Meal Plan" documented, "A menu including meals and snacks will be planned to include five food offerings daily. The menu will be planned to use a variety of foods with reference to the USDA "Food Guide Pyramid" and the Food and Nutrition Board National Academy of Sciences RDA's." The procedure stated the "brunch and supper/dinner meal would be served to the residents in the dining room; the evening food offering would include a high-quality protein, a starch item, fruit, puddings, milk and juice and the nursing staff would distribute the food and assist residents with eating as required; and two additional food offerings will be prepared by culinary staff and delivered to the resident areas to be offered by nursing staff." During an interview on 9/23/21, at 1:11 p.m. the menus and the facility policy for the meal plan were reviewed with the registered dietitian (RD). RD verified the facility should have been offering the five-food offering a day and the menu should have been planned to include food groups in	F 803	The policy 'Menu standards' was reviewed and remains appropriate. The facility uses MealSuite Foodservice software to ensure all meals are planned to provide resident nutritionally adequate meal options. Dieticians and culinary leaders will receive education on the nutritional adequacy of the menu through mealsuite. The culinary director or designee will complete random audits of weekly and daily menus to ensure nutritional adequacy. These audits will be conducted 3 times a week for 2 weeks, weekly for 2 weeks, and then 3x per month x 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 28	F 803		

accordance with the USDA "Food Guide Pyramid." The USDA website, accessed at myplate.gov on 9/23/21, recommended women over 60 get 2 to 3 cups of vegetables per day and men over 60 get 2.5 to 3.5 cups a day. The recommendations were reviewed with the RD along with week one's menus.

Review of week Monday 9/20/21, through Sunday 9/26/21, one's menus revealed the facility did not have 2 to 3 cups of vegetables planned into the menus on six of the seven days reviewed. Review of the menus revealed the following:

-On Monday, the vegetables included ½ cup of carrots and 1 cup of chicken and rice casserole which would contain a small amount of vegetables. This was a total of 1.5 cups of vegetables for the day.

-On Tuesday, the vegetables included ½ cup tater tots, 3 ounces of mashed potatoes, and ½ cup broccoli. This was a total of 1.5 cups of vegetables for the day.

-On Wednesday, the vegetables included ½ cup boiled potatoes and ½ cup of California vegetable mix; a total of 1 cup of vegetables for the day.

-On Thursday, the only vegetables would have been the vegetables in the chicken pot pie and in the Italian wedding soup. No other vegetables were listed on the menu.

-On Friday, the vegetables included ½ cup hash browns and ½ cup Harvard beets; a total of 1 cup for the day.

-On Sunday, the vegetables included ½ cup of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 29 sweet potatoes and ½ cup of green beans; a total of one cup for the day. The RD verified the above menus did not contain the USDA-recommended amount of vegetables. She also stated with the five meal per day/resident choice meal plan, a lot of the decision-making of what the residents received or if the residents received the 1:30 p.m. and 7:00 p.m. snacks laid heavily on what the nurse aides decided. The RD verified the policy stated the snacks were to be prepared by the culinary staff and delivered to the unit; however, it was left to the aides to obtain and prepare the food from the kitchenettes.	F 803		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.	F 809		11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure a snack was offered to residents. This had the potential to negatively affect the nutrition status of all 110 residents in the facility. Findings include: The undated facility policy titled, "Resident Choice Meal Plan" documented, "A menu including meals and snacks will be planned to include five food offerings daily." The policy indicated a snack would be offered in the evening and would include a high-quality protein, a starch item, fruit, puddings, milk and juice and the nursing staff would distribute the food and assist residents with eating as required. The undated facility document titled, "Mealtimes" documented "Continental Breakfast" was served in each neighborhood from 6:30 a.m. to 9:30 a.m.; at 10:30 a.m., "Brunch" was served in the dining rooms; at 1:30 p.m., a snack was served in each neighborhood; at 4:30 p.m., dinner was served in each dining room; and at 7:00 p.m., the "Evening meal/snack" was served in each neighborhood. During the survey dates of 9/20/21 through 9/23/21 observations and interviews conducted with staff and residents during the survey revealed the facility did not consistently offer all residents the 1:30 p.m. and 7:00 p.m. snack. A group meeting was conducted with 11 residents on 9/21/21, at 1:00 p.m. in the facility chapel. During the meeting, the residents stated they	F 809	The policy 'Meal Times' was reviewed and remains current. The 1:30pm and 7pm snack options and delivery process were reviewed and updated to ensure all residents are offered nourishing food and beverage options at all snack time. Culinary and nursing staff will be educated on the snack delivery process including offering and documenting resident acceptance of offered snacks. The culinary director or designee will monitor compliance. Random audits of offering snack to all residents will be conducted 5 times a week x 2 weeks, 3 times a week x 2 weeks, weekly x2 weeks, then 3x per month x 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 31	F 809		

were not offered snacks at 1:30 p.m. and at 7:00 p.m..

During an interview on 9/22/21, at 2:00 p.m., R25 stated she was only offered food at 5:00 a.m., 10:30 a.m., and at 4:30 p.m. R25 stated she was not offered any food at 1:30 p.m. nor at 7:00 p.m. When asked if she would like a snack at 1:30 p.m. and 7:00 p.m., R25 stated yes.

During an interview on 9/22/21, at 2:27 p.m. R21 stated sometimes she is offered a snack at 1:30 p.m. and at night however she is not always offered a snack.

During an interview on 9/22/21, at 2:30 p.m., R27 stated she was not offered snacks between meals or before bedtime.

During an interview on 9/22/21, at 2:35 p.m., R84 stated he was not offered a snack at 1:30 p.m. nor after the 4:30 p.m. meal. He stated he would take one if one were offered.

During an interview on 9/22/21, at 2:42 p.m., R102 stated he was not offered any snacks between meals or at bedtime.

During an interview on 09/22/21 at 2:45 p.m., R18 stated the staff stopped offering a snack in the afternoon about six months ago, and she had lived in the facility for over a year and had never been offered a snack at bedtime.

During an interview on 9/22/21, at 7:27 p.m., nursing assistant (NA)-17 stated she was working the 6:00 p.m. to 6:00 a.m. shift, but she was not sure if they passed snacks on the unit at 7:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 32	F 809		

During an interview on 9/22/21, at 8:03 p.m., NA-18 stated she routinely worked from 2:30 p.m. to 11:00 p.m.. NA-18 stated she only gave two residents a snack that evening; she stated she did not offer a snack to every resident in the evening.

During an interview on 9/22/21, at 1:00 p.m., NA-16 stated she did not offer the 1:30 p.m. snack to all the residents. She stated she gave the residents a snack only if they ask for one.

An interview with licensed practical nurse (LPN)-8 on 9/23/21, at 7:15 p.m. revealed the residents on Oak Crossing were not offered snacks at 7:00 p.m., unless they specifically asked for them.

During an interview on 9/22/21, at 7:17 p.m., R39 and R45 each stated they do not get offered snacks at night and they each stated they would like one.

During an interview on 9/22/21, at 7:38 p.m. R12 stated he was not offered a nighttime snack. R12 stated he would take one if one were offered. He stated he could not remember if he got a 1:30 p.m. snack.

During an interview on 9/22/21, at 7:51 p.m., R16 stated she was not offered snacks at 1:30 p.m. or at 7:00 p.m., but she would take a snack if one were offered to her.

During an interview on 9/23/21, at 1:11 p.m., the registered dietician stated with the five meal per day/resident choice meal plan, a lot of the decision-making of what the residents received or if the residents received the 1:30 p.m. and 7:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 33 p.m. snacks laid heavily on what the nurse aides decided. The registered dietician verified the policy stated the snacks were to be prepared by the culinary staff and delivered to the unit; however, it was left to the aides to obtain and prepare the food from the kitchenettes.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to ensure foods were held at a safe temperature level during storage and serving. This involved one of four kitchenettes (Cedar Terrace/Cypress Court) and had the potential to spread foodborne illness to 30 of 110 residents in the facility.	F 812	The policies 'Refrigerator and Freezer Temperature Monitoring' and 'Maintaining Proper Food Temp during Food Service' were reviewed and remain appropriate. All refrigerator and freezer locations have been reviewed to make sure all have thermometers, one was added if needed.	11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 34 Findings include: On 9/21/21, at 9:30 a.m., the refrigerator in the Cedar Terrace/Cypress Court kitchenette was inspected with the Director of Culinary Services (DCS). At the time of the tour, there was no thermometer in the refrigerator and the refrigerator dial was set on four. The refrigerator contained milk, lunch meats, cheese, potato salad, and health shakes. The DCS verified there was no thermometer in the refrigerator and stated the refrigerator was supposed to be set on two and not four. The temperature of a health shake from the refrigerator was obtained at the time of the observation and measured 42.4 degrees Fahrenheit (F). The DCS stated the shake should have been stored at 41 degrees F or colder. On 9/22/21, the meal service was observed in the Cedar Terrace/Cypress Court kitchenette from 10:30 a.m. to 11:03 a.m. During this time, the cheese, sliced roast beef, egg salad, sliced turkey, and ham were observed in plastic containers sitting on the countertop without any method to ensure they stayed cold. At 11:03 a.m., the last tray on the unit was served and Food Service Employee (FSE)-24 obtained the temperature of the food items at the request of the surveyor using the facility thermometer. The roast beef was 54 degrees F; the egg salad was 62.4 degrees F; the turkey was 53 degrees F; the ham was 50 degrees F; the cheese 53.7 degrees F, and the lettuce was 56.8 degrees F. After taking the temperature of the food items, FSE-24 put the lids on the containers and placed them back in the refrigerator. She stated she used the same containers of lunchmeats, cheese, egg salad, and lettuce at each meal she served and they had never put them on ice. She stated she	F 812	All potentially hazardous food will be served at the proper temperatures of 41F or below to 135F or above at all times. Culinary staff will be educated on Refrigerator and Freezer Temperature Monitoring, the policy and procedure of temping food prior to serving as well as storing items during serving to maintain appropriate temperatures. The culinary director or designee will monitor compliance. Audits of refrigerators/freezer temperatures a well as audits of proper serving temperatures and storage of food during serving will be conducted 2x per week x 2 weeks, weekly x 2 weeks, then 3x per month x 2 months. Audits will be presented to Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 35 did not take the temperature of these food items prior to serving the meal. In addition, the temperature of the puree egg bake on the steamtable was 130 degrees F. FSE-24 verified each of the temperatures as she obtained them. On 9/23/21, at 9:42 a.m., the DCS stated the same containers of lunch meat, cheese, potato salad, and egg salad were used for up to seven days or until it was gone, and the same containers were set out on the countertop for each meal. The DCS stated she was aware the food was being served from the countertop without a method to keep it cold. The undated facility policy titled, "Maintaining Proper Food Temperature During Food Service" indicated the holding temperature of cold foods should be 41 degrees F and the temperature of hot foods should be 135 degrees F. On 9/23/21, at 1:07 p.m., the policy was reviewed with Registered Dietitian. She stated she would expect the cold food items to be held at 41 degrees F or colder and the hot food items to be held at 135 degrees F in accordance with the facility policy. She stated she would expect the staff to keep the cold food items in the refrigerator or have them placed on ice during serving.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement measures to prevent the spread of infection when: 1. Urinary catheter tubing was uncovered and in contact with the floor for two (Resident (R) 80 and R103) of two sampled with urinary catheters, which created a potential for bacteria to travel up the tubing to the bladder; 2. Wound vac (vacuum-assisted closure of a wound - a type of therapy to help wounds heal) tubing was on the floor for one (R96) of one sampled resident with a wound vac, which created a potential for bacteria to travel up the tubing to the wound; and 3. Staff failed to perform adequate hand hygiene when preparing and serving meals, which had the potential for the spread of food borne illnesses for the 20 residents eating in the Cypress Court	F 880	The policies 'Hand Hygiene' and 'Prevention of CAUTI and Collection Device associated Infections' were reviewed and revised. R 80s catheter has since been discontinued on 9/25/21. R103 received a catheter collection bag cover and orders were added for nurses and CNAs to ensure staff are verifying that tubing of the catheter is not touching the ground. R 103's care plan and NAR care guides were updated as indicated. R 96 has orders placed in his chart for nurses and CNAs to ensure staff are verifying that tubing of the wound vac is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 dining room. Findings include: 1. Review of R80's significant change of condition (SCOC) "Minimum Data Set (MDS)" assessment with an Assessment Reference Date (ARD) of 8/27/21, revealed R80 was admitted to the facility on 8/3/21. She had a Brief Interview of Mental Status (BIMS) score of 15, indicating that she was cognitively intact, and she had an indwelling urinary catheter. Observation of R80 on 9/20/21, at 12:17 p.m. revealed R80 was in her wheelchair in the hallway near the nurses' station on the first floor Transitional Care Unit (TCU), along with a visitor. The tubing for the resident's urinary catheter was making contact with the floor and dragged along the floor as she moved back down the hall to her room. In an interview with R80 on 9/21/21, at 4:07 p.m., R80 stated she was not aware her catheter tubing should not be on the floor, but that staff were the ones who positioned the tubing. 2. Review of R103's admission MDS assessment, with an ARD of 9/8/21, revealed he scored a 15 on the BIMS, indicating intact cognition. R103 required extensive assistance by staff for mobility and used an indwelling urinary catheter. Observation on 9/20/21, at 9:48 a.m. revealed R103 was sitting in his room in a chair at the foot of his bed. The door to the room was open and R103 was viewable by anyone in the hall. R103's uncovered catheter drain bag was in contact with the floor.	F 880	not touching the ground. R 96's care plan and NAR care guides were updated as indicated. RN-24 was educated that tubing such wound vac or catheter tubing should not be touching the ground at anytime. All other residents with catheters or wound vacs were provided a collection bag cover and have had orders entered for nurses and CNAs to ensure staff are verifying that tubing of the catheter/wound vac is not touching the ground. Care plans and care guides were updated where indicated. NA-15 was educated on 10/25/21 on hand hygiene while serving meals and the importance of sanitizing hands between touch points in the meal serving process. Facility staff will be educated on the Hand hygiene and the Prevention of CAUTI and Collection Device associated Infections policies a well as expectations of when to perform hand hygiene during meal service as well as keeping catheter and wound vac tubing off the ground to prevent infection. DON or designee will ensure compliance. Audits of hand hygiene during meal service and catheter/wound vac tubing remaining off the ground will be completed on all shifts everyday for one week then 3x per week for 2 weeks, weekly x 2 weeks, then 3x per month x2 months. Audits will be presented and reviewed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 An interview with nursing assistant (NA)-7 on 9/20/21, at 9:50 a.m. revealed catheter bags should always be off the floor and covered to prevent the spread of infection. An interview with registered nurse (RN) 3 on 9/22/21, at 8:27 a.m. revealed R103's catheter drain bag should never be on the floor. 3. Review of R96's SCOC "MDS," with an ARD of 9/7/21, revealed he was admitted to the facility on 8/16/21. He had a BIMS score of 14, indicating he was cognitively intact, and had an unhealed stage IV pressure ulcer. Review of R96's September 2021 Physician's Orders, located under the Orders tab of his electronic medical record (EMR) revealed he required a wound vac to a stage IV pressure ulcer on his sacrum beginning on 8/16/21. Observation of R96 on 9/20/21, at 1:47 p.m. revealed R96 was sitting in his room in his wheelchair. The wound vac pump was visible, attached to the back of his wheelchair near the seat pan, with the tubing extending from the pump to his sacrum. The vac's alarm was sounding, indicating it required attention from a nurse. The tubing was resting on the floor between the pump and the resident. RN-24 entered the room to adjust R96's wound vac, which caused him to squat down behind R96's wheelchair and look under the seat. RN-24 made slight adjustments to the pump mechanism, which stopped the alarm. RN-24 stood and left the room without adjusting the tubing. When asked, RN-24 stated he had not realized the tubing was on the floor and returned to adjust it.	F 880	Quality Council, who will recommend changes and om-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 In an interview with the Infection Prevention (IP) nurse on 9/23/21, at 10:31 a.m., the IP nurse stated neither catheter tubing or wound vac tubing should be on the floor, as they may come in contact with bacteria that can travel up the outside of the tubing and create infections for the residents. An interview with the director of nursing (DON) on 9/23/21, at 11:00 a.m. revealed the facility did not have policies that specifically directed for tubing to not be in contact with the floor, but standard infection practices dictated that tubing was not to be in contact with the floor. An interview with the Administrator on 9/23/21, at 4:26 p.m. revealed it would be his expectation that the facility followed recognized standards for infection prevention and control. 4. Review of the facility's 9/20/21, "Daily Census Sheet" revealed 20 residents dined in the Cedar Terrace dining room. On 9/22/21, at 10:40 a.m., NA-15 was observed assisting with assembling and serving trays in the Cedar Terrace kitchenette and dining room. She was observed to remove soiled plates from tables, removed a clothing protector off one resident, then touch a clean meal ticket, went into the kitchenette, open the refrigerator door, obtain a container of milk, and pour the milk for a resident. She obtained ice from the ice machine touching the button on the ice machine. She did not wash or sanitize her hands between touching the soiled items and touching the refrigerator, container of milk, meal ticket, or the ice machine.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 At 10:58 a.m., just as she was getting ready to carry a tray down the hall, NA-15 was stopped and asked if she had washed or sanitized her hands between each of the above tasks and she stated she had not because she forgot to. On 9/23/21, at 9:42 a.m. this finding was shared with Director of Culinary Services. She stated the staff were expected to wash their hands after serving residents and removing soiled plates and before coming into the kitchenette and getting items out of the refrigerator and ice. The facility policy titled, "Hand Hygiene," with an effective date of June 2017, revealed it was the facility's policy to perform hand hygiene using soap and water between assisting residents and handling food.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure one resident's (R48) call light, out of 26 Initial Pool residents, was functioning properly and was in reach. This failure placed R48 at risk for not receiving assistance in the event of an emergency or need.	F 919	The facility developed and implemented a 'Call Light procedure' on 10/26/21. R48's call light was tested on 10/26/21 with no issues identified with function, also call light was clipped to resident's body and accessible for use.	11/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 42 Findings include: Review of R48's significant change Minimum Data Set assessment, with an Assessment Reference Date of 08/08/21, revealed he had a Brief Interview for Mental Status score of 15, indicating he was cognitively intact. R48 required extensive assistance of two staff for bed mobility, transfers, and toilet use; did not walk; and required extensive assistance of one for dressing and personal hygiene. Review of R48's Care Plan, located in the electronic medical record Care Plan tab, with a start date of 08/18/21, revealed it addressed R48's need for assistance with activities of daily living and the approaches included keeping the call light in reach at all times. On 09/20/21, at 12:16 p.m., R48 was observed seated in a wheelchair in his room. The resident appeared visibly upset and stated when he pushed his call light, it did not work, and staff did not come. The call light was tested and did not function. At 12:17 p.m., nurse aide (NA)-16 was notified about the call light not working and she verified it did not work. She took the call light off the wall in his bathroom and placed it on the over bed table in his room along with a metal bell, leaving his bathroom without a call light. On 09/22/21, at 5:26 p.m., the call light had been placed back in the bathroom and Clinical Manger (CM)-19 was informed R48 did not have a call light in his room. She went to the room and verified he did not have a call light in his room. On 09/22/21, at 7:35 p.m., R48's room was entered with registered nurse (RN)-25 as she was	F 919	Facility call light system was in process of being replaced at time of survey and has been finalized as of 10/15/21. All resident rooms now have new call light boxes and cords including R48. Quality assurance of the new call light system was completed by ELDR project manager on 10/15/21. facility staff will be educated on the call light procedure which includes placing call lights within resident reach and if noted to be not be functioning appropriately to complete a maintenance ticket promptly to follow up and ensure resident has an alternative way to notify staff of needs. DON or designee will monitor compliance. Audits of call light functioning and of being within resident reach and will occur 3x per week x 2 weeks, weekly x 2 weeks, then 3x per month x 2 months. Audits will be presented to Quality Council who will recommend changes and on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 43 passing medication to the resident. Upon entering the room, the resident was observed in bed on his back with the lights out. No staff were present in the room prior to entering the room and the resident did not have a call light in his room, as it had been placed back in the bathroom and the metal bell was located on the far side of his bedside table and not in reach of the resident. RN-25 verified the resident did not have access to a call light. CM-19 was immediately informed, and she verified the resident did not have access to his call light.	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 22, 2021. At the time of this survey, Cerenity Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/29/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Cerenity Care Center White Bear Lake is a 2-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1957 and was determined to be of Type II(222) construction. In 1974, addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1983, another addition was constructed to the West Wing that was determined to be of Type II (222) construction. In 2013, a new 2 story addition was constructed to the west as a TCU unit.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 138 beds and had a census of 112 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=E	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain occupancy separations per NFPA 101 (2012 edition), Life Safety Code, section 19.1.3.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that zone 6 does not have a two-hour fire-rated separation between the	K 133	1. build a fire rated wall and fire rated door between the nursing home and Zone 6. We have signed a contract for a wall and door separation between the nursing home and Zone 6 with Pope Architects. There are many stages f approval, securing bids for construction and purchasing materials. 2. This will not re-occur as the wall is a permeant structure. 3. Maintenance Director will contact the Architect and oversee construction of the	11/19/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 133	Continued From page 3 buildings where there was a change in occupancy. This deficient condition was verified by the Facility Administrator.	K 133	wall. 4. We are going to try to complete by January 5, 2022, if unable for any reason we cannot complete we are going to ask for a waiver to complete project 5. Applied for wavier 11/19/21	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress per NFPA 101 (2012 edition), Life Safety Code, sections, 19.2.1, 7.1.10.1, 7.10.1.2.1, 7.1.3.2.1, and 7.2.1.15.7. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that there was a sign outside of the exit stairwell by Room 1113 that stated NOT AN EXIT. 2. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that there was under the stairs in the egress stairwell by Room 1113.	K 211	1. Sign was removed on 10/22/21, wheelchair was removed on 10/25/21, table removed from doorway on 9/22/21 day of the survey, and trees and plants moved from chapel door on 9/22/21. 2. In-service for all staff on instruction that means of egress must be free of obstruction at all times and this was added to our New Hire Orientation. Education to all staff was Oct 28th and 29th. 3. Maintenance staff will audit these items weekly for one month. After one month of compliance and turn in results to QA committee. Maintenance staff will audit monthly for 3 months and report to QA, after monthly compliance, the issue will be resolved. 4.Director of Maintenance and	11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 4 3. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that in the dining room by Room 1104, the exit door is blocked by a table. 4. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the chapel exit door was blocked by an artificial tree. These deficient conditions were verified by the Facility Administrator.	K 211	Maintenance Assistants will ensure compliance. 5. Credible allegation of compliance by 11/1/21.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler	K 222		11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 5 system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit doors per NFPA 101 (2012 edition), Life Safety Code, section 19.2.2.2.5. This deficient condition could have a patterned impact on the residents within the	K 222	1. Lighted exit sign and not exit sign has been replaced on the door with the lock. 2. Any new doors installed will not have a deadbolt locking ability-all doors have been checked for inappropriate deadbolt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 6 facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that there was a deadbolt lock on the exit door on the 1st-floor dining room to the outside area. This deficient condition was verified by the Facility Administrator.	K 222	lock 10/25/21. 3. Maintenance will monitor door construction to ensure proper locks are installed. 4. Credible allegation of compliance by 11/1/21	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairways per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.1.3.2.1, and 8.3.5.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that a three-inch hole was found in the wall inside the exit stairwell located by the art room on the 1st floor.	K 225	1. Three inch hold was patched and door stop put in place in the exit stairwell by the art room in the stairwell to prevent wall damage. 2. All stairwell exits were inspected for holes-especially looking for door damage. 3. Maintenance techs will monitor stairwells for holes and penetrations. Staff and guests are to submit a repair ticket if any holes are created or seen. 4. Maintenance director or Maintenance assistants will tour monthly on and ongoing basis for any holes, staff are to report holes and repairs tickets if any	11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 225	Continued From page 7 This deficient condition was verified by the Facility Administrator.	K 225	others are found. 5. Credible allegation of compliance by 11/1/21	
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the exit discharge per NFPA 101 (2012 edition), Life Safety Code, section 19.2.7, 7.1.6.2, and 7.1.6.3. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the egress discharge sidewalk which travels through the garden, the area by the gate, has an uneven walking surface. This deficient condition was verified by the Facility Administrator.	K 271	1. Sidewalk needs to be repaired with any quarter inch variance in sidewalk leading from egress to side walk, several areas identified and bids being secured for review. The fence and locking system will be updated to meet current life safety code on November 3rd, 2021. 2. This is the only locked courtyard that would apply to this situation on our property. Sidewalks will be monitor during grounds keeping. 3. Maintenance tech will monitor ongoing function of the gate during regular fire drills. 4. Maintenance director and maintenance assistant will audit monthly to ensure proper gate function. 5. Credible allegation of compliance-11/1/21.	11/1/21
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 8 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 19.3.6.3.5. These deficient conditions could have a patterned impact on the residents within the facility. Findings include:	K 321	1. Utility rooms latch repaired 10/25/21, oxygen room latch repaired 10/25/21, soiled utility room on TCU 1 latches repaired by installing passive hardware to minimize staff inconvenience on 10/25/21. Utility room door closure sped up 10/25/21. 2.Educate staff on the fire marshal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 9 1. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that in the utility room by Room 1110, the door did not latch when it was tested. 2. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the oxygen room located by Room 1113, the door did not latch when it was tested. 3. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the door to the soiled linen room by Room 106 did not latch when it was tested. 4. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the door to the soiled linen room by Room 118 did not latch when it was tested. 5. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the door to the soiled linen room by Room 218 did not latch when it was tested. These deficient conditions were verified by the Facility Administrator.	K 321	regulations and safety measures necessary to keep residents safe. Blocking of doorways, and filling key holes in not acceptable. If any door isn't functioning properly a repair ticket should be submitted. Education October 28th and 29th. 3. Any door closures and door latches not functioning properly will be repaired. 4. During regular facility tour, maintenance will inspect door latches and door closures to ensure this doesn't reoccur. 5. Credible allegation of compliance 11/1/21	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited	K 324		11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 10 cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain, test and inspect or install per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the stove in the therapy room was not locked out. This deficient condition was verified by the Facility Administrator.	K 324	1. Locking Key Pad for key in kitchen area-key access only be designated staff. 2. After every use, the stove will be locked out and key stored in key box. 3. Staff were educated on proper lock out process of Key in stove- Education Oct 28th and 29th. 4. The therapy director will ensure this practice is safe and followed 5. Credible allegation of compliance 11/1/21	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 11 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install fire alarm smoke detection per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the smoke detector located by Room 1113 was within 36 inches of an air defuser. This deficient condition was verified by the Facility Administrator.	K 341	1. Smoke detector in room 1113 was moved 36 inches from the air diffuser-Symplex Grinnell moved smoke detector 10/29/21. 2.Smoke detector is permanently placed and will not move-Symplex will audit the entire facility to ensure proper distancing of all smoke detectors. This will occur on 10/29/21. 3. Facility wide tour of smoke detectors was conducted and no others were found 10/29/21 4. Maintenance director and staff will ensure any movement of smoke detectors will comply with NFPA building codes. 5. Credible allegation of compliance 11/1/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 12	K 345		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3 through 14.4.5.3.7. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that there was no record of a smoke detector sensitivity test being completed in the last two years. This deficient condition was verified by the Facility Administrator.	K 345	The smoke sensitivity test results will be placed in the Life Safety Manual. A backup copy will be recorded and stored with Tells maintenance software which is a preventive maintenance software and an additional copy sent to the safety committee to ensure completion, storage and access to the reports are always available. The Director of environmental services will secure a copy of all life safety documents. Copies will be put in and stored in the life safety manual, uploaded to Tells and reported to the safety committee. The committee will review, maintain a copy of the life safety documentation and ensure compliance. This will provide multiple locations of the required documentation.	11/11/21
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation	K 351		11/25/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 13 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install an automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.15.1.2.18 through 8.15.1.2.18.4. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM and 6:00 PM, it was revealed that there was no fire sprinkler protection under the overhangs of the first and second stories, where residents are allowed to sit. This deficient condition was verified by the	K 351	Pope architect is gathering all current documentation related to the areas in question. All documentation will be provided to you within the next 2 weeks for your review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 14 Administrator.	K 351		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.4. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it	K 353	1. Escutcheon plate was properly placed-complete 11/1/21. 2. Escutcheon plates will be monitored by all employees, anyone who sees a missing or moved ring will submit a work order. 3.Escutcheon plates inspection will be added to monthly rounding by maintenance staff. 4. Director of Maintenance or maintenance tech will ensure compliance. 5. Credible allegation of compliance 11/1/21	11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 15 was revealed that the escutcheon plate was falling off of the sidewall sprinkler located in stairwell A on the 2nd floor. This deficient condition was verified by the Facility Administrator.	K 353		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3and 8.5.6.1 through 8.5.6.5. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that a penetration was found above the ceiling in the TCU 2nd floor smoke barrier.	K 372	1. Smoke barrier TCU 2nd floor was filled 3M Fire barrier, smoker barrier above ceiling room 1120 was filled 10/25/21 with 3M smoke fire barrier, smoke barrier in room 1D was repaired with 3M Fire barrier on 10/25/21. 2. Any construction done will include contractor education of smoke barrier code. Any bids accepted must meet fire marshal regulations. 3. Maintenance will inspect any construction on fire barriers before construction is complete to ensure they	11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 16 2. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that a penetration was found in the smoke barrier above the ceiling located by Room 1120. 3. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that a penetration was found above the door located by Room 1 D in the smoke barrier. These deficient conditions were verified by the Facility Administrator.	K 372	meet fire code. Payment will be withheld until inspection is complete. 4. Maintenance department will ensure Fire Barriers are properly maintained and construction is complete in the proper manor. 5. Credible allegation of completion 11/1/21	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.6, 19.3.7.8, and 8.5.4.1. These deficient conditions could have a widespread	K 374	1. Door closure was adjusted by room 1E and Smoke Barrier Door by room 200 was adjusted, both function properly 10/25/21. 2. During fire drills staff are to report any doors that do not close properly-submit a	11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 17 impact on the residents within the facility. Findings include: 1. On 09/22/2021 between 9:00 AM to 6:00 PM, it was revealed that the smoke barrier door by Room 1E and the recreation services did not close when tested. 2. On 09/22/2021 between 9:00 AM to 6:00 PM, it was revealed that the smoke barrier door in the TCU by Room 200 did not close when tested These deficient conditions were verified by the Facility Administrator.	K 374	work ticket. Maintenance will repair the door closures that fail to close. 3. Door closures will be tested monthly to ensure proper function during fire drills. 4. Maintenance director or maintenance assistants will ensure proper functioning of the door closures. 5. Credible allegation of compliance 11/1/21	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition),	K 711	Ensure fire plan indicates the transmission of the fire alarm to the fire department-policy does include call 911	11/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 711	Continued From page 18 Life Safety Code section 19.7.2.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the facility fire plan does not indicate the transmission of the fire alarm to the fire department. This deficient condition was verified by the Facility Administrator.	K 711	and automatic notification happens when fire alarm is triggered or pulled. See email sent on 11/15/21.	
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a space heater policy per NFPA 101 (2012 edition), Life Safety Code section 19.7.8. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the facility does not have a current policy on the use of space heaters within the facility.	K 781	No space heaters in resident rooms-see attachment C for policy.	10/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 781	Continued From page 19 This condition was verified by the Facility Administrator.	K 781		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that electrical breaker panels were found to be unlocked by Rooms 1104 and 1120. This deficient condition was verified by the Facility Administrator.	K 911	1. All electrical panels locked-10/27/21 2. Educate anyone working on electrical panels, that they must be locked after work is complete, education Oct 28th and 29th. 3. Maintenance check for electrical panel locking, and locked them 10/25/21 4. Maintenance director or staff will ensure all electric panels are locked. 5. Credible allegation of compliance	11/1/21
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		11/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 20 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the emergency power generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.6.1, and NFPA 110 (2010 edition), sections 5.1.1 and 7.3.1. These deficient conditions could have a	K 918	1. Reliable source of energy-Pioneer Critical Power 2. Discussion with Pioneer Critical Power determined generator lighting is sufficient, but need to lower e-stop button to be accessible to all people in the event of an emergency. Pioneer Critical power will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 21 widespread impact on the residents within the facility. Findings include: 1. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the facility does not have a letter of reliable services from the gas company. 2. On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that the facility does not have emergency backup lighting at the two generator locations. These deficient conditions were verified by the Facility Administrator.	K 918	complete this work, awaiting date from Pioneer Critical power for this to occur. Stop switch has been lowered to an accessible height for all employees - 11/8/21 excell will be providing a letter of continuous service within 30 days - emailed to Fire Marshall switch and letter are permant no follow up or education required	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed	K 920		11/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 22 immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to utilize extension cords and power-taps per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.1.1, 10.2.3.6, and 10.2.4 and NFPA 70 (2011 edition), National Electrical Code, section 400.5. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/22/2021, between 9:00 AM to 6:00 PM, it was revealed that an extension cord was found in the laundry room that was plugged into a relocatable power tap, which was also plugged into another relocatable power tap. This deficient condition was verified by the Facility Administrator.	K 920	1. Replace laundry room extension cord 9/30/21 2. New electrical boxes installed-no extension cord exists 9/30/21 3. This was construction in process during survey completed 9/30/21 4. Contractors will be monitored for acceptable use of extension cords and monitored by the maintenance department. 5. Credible allegation of compliance 11/1/21	