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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q7FP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00923

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

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

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

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

6. DATE OF SURVEY **7/27/2018** (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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susie Haben, Unit Supervisor 07/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245300
July 30, 2018

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

Dear Mr. McDonald:

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

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

Effective July 2, 2018 the above facility is certified for:

138 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

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(L5) **WHITE BEAR LAKE, MN** (L6) **55110**

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3. Termination **4. CHOW**
5. Validation **6. Complaint**
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8. Full Survey After Complaint

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

6. DATE OF SURVEY **05/23/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
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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**	
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
08/31

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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17. SURVEYOR SIGNATURE Date :
Susan Miller, HFE NE II 06/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/20/2018 (L20)

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23. LTC AGREEMENT BEGINNING DATE
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(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
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01-Merger, Closure
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04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 12, 2018

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

RE: Project Number S5300028

Dear Mr. McDonald:

On May 23, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 2, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 2, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by August 23, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 23, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	05/23/2018

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 survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 5/20-5/23/18, during a recertification survey. The facility is in compliance with Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On May 20, 21, 22 and 23, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		7/2/18

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

Electronically Signed | 06/20/2018

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 _____	05/23/2018

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 686	Continued From page 1 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning services for 1 of 3 residents (R48) who was identified at risk for pressure ulcers and required staff assitance to reposition. Findings include: Review of R48's face sheet indicated R48's diagnosis include: Alzheimer's disease, Degenerative disease of nervous system, altered mental status, and contracture, right hand. Review of R48's skin risk assessment dated 6/29/2017, indicated R48 received total assist with transfers, bed mobility, toileting, and was at very high risk for impaired skin integrity. Review of R48's current plan of care indicated staff were to turn and reposition the resident every 2 hours. On 5/22/18, R48 was continuously observed to remain seated in a high backed wheelchair from 8:34 a.m. until 11:44 a.m. (3 hours and 10 minutes). During interview 5/22/18 at 11:31 a.m., licensed practical nurse (LPN)- A stated R48 should be repositioned every two hours, and asked NA-B to lay R48 down.	F 686	The Facility has policies and procedures in place to ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual clinical condition demonstrates that were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standard of practice, to promote healing, prevent infection and prevent new ulcers from developing. The policy 'Prevention and Treatment of Skin Breakdown' was reviewed and remains appropriate. Licensed staff completed a Skin Risk Assessment w/Braden observation on 6/12/18 for R48, her Braden was a 10 putting her at high risk for skin breakdown. R48 is dependent with transfers, bed mobility, and toileting and is to be repositioned every 2 hours. Her care plan was reviewed and updated. Licensed nursing staff reviewed all residents deemed At Risk for skin breakdown. Care plan, treatment orders, current interventions, care sheets, and progress notes of all At Risk residents were reviewed and updated as deemed	

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 _____	05/23/2018

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 686	Continued From page 2 At 11:44 a.m. on 5/22/18, R48 was transferred with a mechanical lift out of the wheelchair and into bed. At 11:58 a.m., R48's incontinence brief was removed and R48 was observed to have 2 quarter sized slightly pink areas on the skin at the top of the coccyx. Nursing assistant (NA)-B indicated that barrier cream was applied when a resident "had any pink or red areas," and applied barrier cream to R48's coccyx. Review of the facility's undated policy, Prevention and Treatment of Skin Breakdown, included: "care and service are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur."	F 686	appropriate. Nursing staff will be educated on the policy 'Prevention and Treatment of Kin Breakdown' and how to identify who needs repositioning. This education will occur June 27th and 28th, 2018. DON or designee will ensure and monitor compliance. Audits will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3 times per month x2months. Audits will be presented and reviewed at Quality Council, who will recommend changes and ongoing monitoring/auditing after analysis.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		7/2/18

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F 688	Continued From page 3 Based on observation, interview and document review, the facility failed to ensure range of motion services were attempted for 1 of 2 residents (R95) reviewed who had limited range of motion to the upper extremities. Findings include: During an initial interview and observation of R95 on 5/21/18 at 9:50 a.m., R95 was observed to have significant deformities of the joints in both hands. R95 stated her arms and hands were mostly numb, and stated she was unaware of any need for range of motion for her hands or arms. Review of the R95's Resident Face Sheet revealed R95 was admitted to the facility on 3/29/17, with a diagnosis of severe deforming rheumatoid arthritis. R95 was not observed to receive any range of motion exercises on 5/21 or 5/22/18. In addition, documentation of any current range of motion exercises could not be found in the record. When interviewed on 5/23/18 at 1:00 p.m., registered nurse (RN)-D stated R95 was not currently receiving any type of range of motion services, but she thought that it had been discussed with the resident and therapy at one time. RN-D said she would try to find documentation of that interaction and rationale for not pursuing range of motion services. During interview on 5/23/18 at 2:30 p.m., RN-D stated she could not locate documentation of rationale for lack of range of motion services for R95. She stated she'd contacted the facility's therapy department earlier 5/23/18 and a staff member of that department had told her range of	F 688	This facility has policy and procedures in place to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and /or to prevent further decrease in range of motion and a resident with limited mobility receives appropriate serves, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. The policy 'Restorative Program' was reviewed and implemented. R95 was referred to Occupational Therapy on 5/24/18 for evaluation of a ROM program to her upper extremities. R95's OT evaluation determined that a staff ROM program was not appropriate due to poor joint integrity but showed R95 was appropriate to treat for wheelchair positioning and modification of utensils to enhance independence with self-feeding. All residents who have shown an ADL decline will be referred to Physical or Occupational therapies for evaluation of programming to improve mobility and prevent further decline. Nursing staff will be educated on the policy 'Restorative Program' and the process to refer residents to therapy. This education will occur June 27th and 28th, 2018. DON or designee will ensure and monitor compliance. Audits will be completed	

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F 688	Continued From page 4 motion services may be beneficial for this resident. RN-D also stated she'd spoken with R95 who was willing to try range of motion services on her upper extremities.	F 688	weekly x4 weeks, and 2 times per month x2 months. Audits will be presented and reviewed at quality council, who will recommend changes and on-going monitoring/auditing after analysis.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R175) identified as being at risk for dehydration and nutritional needs, received the appropriate treatment and services to maintain adequate hydration and nutritional balance based on identified needs.	F 692	The facility has policies and procedures in place to ensure residents maintain acceptable parameters of nutritional status, unless the residents clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; is offered sufficient fluid intake	7/2/18

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F 692	Continued From page 5 Findings include: On 5/21/18, at 2:56 p.m. R175 stated she was on a fluid restriction because of a low sodium level and had a concern about becoming dehydrated. R175 stated that earlier that day, a laboratory technician had a difficult time getting a blood draw completed and had told her the veins kept collapsing. R175 stated that before beginning the fluid restriction she always had good veins and technicians never had problems with drawing blood. During the converesation with R175, a small pitcher of drinking water was noted on an over bed tray table. R175 was seated in a recliner with her feet elevated, wearing anti-embolic stockings, and was noted to have slight swelling (edema) visible in the left foot. On 5/22/18, at 9:33 a.m. registered nurse (RN)-A stated R175 was encouraged to drink something other than water at meal times, and that water wasn't usually provided for her during meals. At 9:35 a.m. RN-A stated nursing assistants told RN-A that R175 did not routinely ask for water, and that R175 was on a 1200 cc (cubic centimeter) free water restriction, so R175 could have other fluids besides water, Jello, popsicles, etc. On 5/22/18, at 11:00 a.m. R175 stated a dietician had spoken to her about adding a nutritional supplement in the evenings for extra fluids. R175 stated she had received the supplement only once since the dietician had spoken to her and nothing since that time, but she couldn't recall the exact date. R175 stated she didn't care to drink milk or water.	F 692	to maintain proper hydration and health; is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. The policy 'Nutritional Supplements' was reviewed and implemented. R175 was reviewed immediately by a Registered dietician during survey and a Nutritional Supplement order was processed 5/22/18. R175 has since discharged the facility. All residents identified at risk for dehydration were reviewed for appropriate supplement and hydration orders, care plans for these residents were reviewed and updated as appropriate. All Registered Dieticians have been educated on the Nutritional Supplement policy and the process of verifying that orders have been saved and auto populate to the EMAR. Education will be completed by June 29th, 2018. DON or designee will ensure and monitor compliance. Audits will be completed 3 times per week x2 weeks, weekly x2 months, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 692	Continued From page 6 A review of documentation regarding R175's hydration status revealed the following: A nursing progress note dated 5/12/18, noted R175 had poor food/fluid intake and was encouraged to drink more fluids; admission orders revealed R175 was admitted to the facility from the hospital on 5/11/18, with a physician order for a 1000 cc fluid restriction; a physician order on 5/14/18, changed the fluid restriction to a 1200 cc free water fluid restriction. A physician visit note dated 5/16/18, revealed R175 had become dehydrated with nausea and vomiting, and had been hospitalized on 5/4/18. The note indicated R175 had dry skin during a physical exam and a sodium lab draw was ordered. The physician note further indicated that according to the hospital discharge summary dated 5/11/18, R175 had a "complex sodium picture" and had received salt tablets during hospitalization. A facility Registered Dietician (RD) Nutritional Assessment dated 5/16/18, indicated R175 was on a regular diet, with a 1200 cc free water restriction related to low sodium levels. The assessment indicated R175 reported a stable weight of 92-97#; and while R175 had a desire to gain weight, attempts had been unsuccessful. According to the documentation, the RD was recommending a daily nutritional supplement. A dictated note from the nurse practitioner dated 5/21/18, indicated R175 was on a "nutrient supplement." However, a review of physician orders from admission on 5/11 to 5/23/18, revealed no physician order for a nutritional supplement. A review of medication and treatment administration records (MAR/TAR) from admission to 5/23/18, revealed R175's free	F 692		

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F 692	Continued From page 7 water intake and weights were being monitored, but there was no documentation indicating a nutritional supplement had been offered to R175. On 5/22/18, at 11:14 a.m. RN-A stated there was no physician's order found for a nutritional supplement. RN-A also verified there was no documentation found on the MAR/TAR indicating R175 had been offered a nutritional supplement. On 5/23/18, at 11:44 a.m. RD-B stated she had forgotten to hit the "save" button on the computer when doing the resident's assessment. RD-B stated when the "save" button is hit, the computer populates the nutritional supplement order from the RD assessment into the computerized MAR/TAR for the nurses to see. That would then ensure the nurses knew to give nutritional supplements. The RD said because the "save" button had not been hit, the supplement had not auto populated to the MAR/TAR. When asked what supplement was recommended, RD-B stated R175 would be taking a chocolate or strawberry Mighty Shake from now on, as R175 likes those two flavors. RD-B stated additional fluid consumption was being implemented by adding chocolate to the milk served to R175, per R175's preference.	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		7/2/18

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F 758	Continued From page 8 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 9 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review , the facility failed to ensure non-pharmacological interventions were developed and implemented for 1 of 5 residents (R97) reviewed for unnecessary medication use who used medication to treat anxiety and depression. Findings include: Record review revealed a Physician Order Report indicating R97 had a physician's order, dated 4/25/18, for Escitalopram oxalate 20 mg (milligrams) every day to treat anxiety and depression. R97's current medication administration history indicated R97 had received the medication every day since admission. R97's current plan of care included a problem statement dated 4/17/18, that included: "Resident has repetitive anxious complaints/concerns (non-health related) (e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing,) r/t (related to) frustration about present need to be here." Interventions for managing the problem area were generic, without specific detail for the resident such as, "Establish a trusting relationship with the resident and family," and, "Emphasize independent actions performed by resident." There were no more specifically identified non-pharmacological approaches identified. When interviewed on 5/23/18 at 2:08 p.m., nursing assistant (NA)-E was asked what non-pharmacological interventions were useful to R97 regarding anxiety. NA-E stated R97 was calmed by art projects, reading the Bible, and	F 758	This facility has policies and procedures in place to ensure residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contradicted, in an effort to discontinue these drugs. The policy 'Psychotropic Drug Use' has been reviewed and implemented. R97 medications, NAR charting, target behaviors and care plans reviewed by the IDT. Resident specific non pharmacological interventions were then added to their care plans. All residents receiving a psychotropic medication had their progress notes, medications, NAR charting, target behaviors, and care plans reviewed by the IDT. Resident specific non pharmacological interventions were then added to their care plans. Nursing staff as well as members of the IDT will be educated on the policy 'Psychotropic medication Use' and the process of identifying residents specific no pharmacologic interventions. This education will occur June 27th and 28th , 2018. DON or designee will ensure and monitor compliance. Audits will be completed weekly x4 weeks, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will	

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F 758	Continued From page 10 talking with her friends. The surveyor then asked NA-E if the use of those interventions was being documented any where to help establish whether or not the approaches were effective. NA-E stated she was unaware of this information being documented anywhere, but just knew it from experience working with the resident. During interview on 5/23/18 at 2:26 p.m., registered nurse (RN)-D, the resident's unit manager, was asked if specific non-pharmacological interventions were documented in the record for R97. She stated she was not aware of any other location in the record where those interventions were documented and she agreed non pharmacologic approaches should be more specifically identified, utilized, and monitored for effectiveness.	F 758	recommend changes and on-going monitoring/auditing after analysis.	
F 880 SS=D	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 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,	F 880		7/2/18

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F 880	Continued From page 11 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 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.	F 880		

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F 880	Continued From page 12 §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 document review, the facility failed to minimize risk for spread of infection related to failure to ensure a resident's glucometer (device used to test blood sugar levels) was disinfected after use for 1 of 2 residents (R94) observed to have a blood glucose check with a glucometer, and failed to utilize appropriate infection control techniques when emptying a urinary catheter drainage bag for 1 of 1 resident (R64) reviewed with a urinary catheter. Findings include: R94 was admitted to the facility on 3/7/18, with a diagnosis of Type 2 diabetes mellitus. R94's physician orders dated 3/7/18-5/23/18, included an order for "blood glucose checks twice a day, before meals." On 5/22/18 at 8:56 a.m., registered nurse (RN)-C was observed to obtain R94's medications and blood glucose meter, which was in a plastic bag with glucose checking supplies. After entering R94's room with permission, RN-C administered R94's medications, washed hands, applied clean gloves, placed a test strip in the blood glucose meter, alcohol disinfected R94's finger and used a lancet to obtain blood for a blood glucose reading. RN-C removed gloves, tossed the gloves	F 880	This facility has an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent development and transmission of communicable diseases and infections. The policy 'Cleaning and Disinfecting of Blood Glucose Meters' was reviewed and remains appropriate. RN-C was immediately re-educated on appropriate sanitizing wipes to use for cleaning of blood glucose meters. All licensed nursing staff will be educated on the policy as well as the correct germicidal wipe to use for cleaning. This education will occur on June 27th and 28th. The policy 'Prevention of Catheter-Associated Urinary Tract Infections' was reviewed and remains appropriate. NA-D was immediately re-educated on correct method of emptying a catheter bag with use of an alcohol wipe to disinfect the catheter port after emptying the catheter bag. All nursing staff will be educated on the policy as well as correct steps of emptying a catheter bag. This education will occur on June 27th and 28th. New NAR and Nurses will be educated	

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F 880	Continued From page 13 in the garbage and cleansed hands. RN-C then placed the blood glucose meter into the plastic bag with the supplies, left the room and tossed the used lancet into a Sharps container. When asked about cleansing the blood glucose meter after the test, RN-C verified she had not done that and would do it later. When asked what sanitizing wipes RN-C used to cleanse the blood glucose meter, RN-C pointed to a container of PDI sani hands instant hand sanitizing wipes. During an interview on 5/22/18, at 2:38 p.m., the assistant director of nursing (ADON) indicated staff should cleanse blood glucose meters following use with germicidal sanitizing wipes, which were contained in a purple top container. The facility's Performing a Blood Glucose Test policy dated 2017 indicated: "Procedure:... 14. Wipe glucose meter with disinfectant and place in resident's individual and labeled plastic bag. Follow manufacturer's recommendation for disinfectant type for meter." The manufacturer PDI material safety data sheets indicated: "Product name Sani Professional Brand Sani-Hands Instant Hand Sanitizing Wipes... Recommended use Disinfecting wipes... Anti-microbial alcohol gel wipes. For external use only." "Product name Super Sani-Cloth Germicidal Disposable Wipes... Product use Disinfectant... Recommended use For external use only... For use on hard surfaces only." This was the product contained in the purple top containers.	F 880	upon hire via competency checklist for catheter emptying and glucose meter cleaning. DON or designee will ensure and monitor compliance. Audits will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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	245300	A. BUILDING _____ B. WING _____	05/23/2018

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F 880	Continued From page 14 R64's face sheet indicated R64 was admitted to the facility on 5/9/18, with diagnoses including urinary tract infection. On 5/22/18, at 9:08 a.m., nursing assistant (NA)-D was observed to cleanse hands and put on a gown and gloves. After NA-D knocked on R64's door, entered and greeted R64, NA-D obtained a graduate container from the bathroom, opened the catheter bag port and held the graduate under the catheter bag port to drain urine. NA-D then brought the graduate to the resident's bathroom, measured the urine, dumped the urine into the toilet, rinsed the graduate with water, wiped it with a paper towel and placed the graduate on top of the resident's toilet. NA-D removed the gown and gloves, tossed them in the garbage, cleansed hands and left the room. When asked, NA-D verified she had not alcohol disinfected the catheter bag port prior to placing the graduate under the catheter bag port to drain urine. NA-D was also observed to not alcohol disinfect the catheter bag port upon procedure completion. NA-D indicated she would alcohol disinfect the catheter bag port when changing the catheter bag. During interview on 5/22/18 at 2:39 p.m., the assistant director of nursing (ADON) indicated staff were supposed to disinfect the catheter drainage bag tubing port with an alcohol wipe when done measuring the uring from the catheter drainage bag. The facility's Prevention of Catheter-Associated Urinary Tract Infection (CAUTI) policy dated 2017 indicated: "Closed Sterile Drainage System:... 3. If the system must be opened, the catheter-tubing junction is disinfected with alcohol before	F 880		

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F 880	Continued From page 15 reconnecting and connectors will be handled to avoid contamination."	F 880		

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K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/20/2018

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cerenity Care Center White Bear Lake is a 2-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1957 and was determined to be of Type II(222) construction. In 1974, addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1983, another addition was constructed to the West Wing that was determined to be of Type II (222) construction. In 2013, a 2 story addition was constructed to the West. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with	K 000		

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K 000	Continued From page 2 full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 138 beds and had a census of 130 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 225 SS=D	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: The facility failed to comply with Life Safety Code (7.2. 19.2.2.3, 19.2.2.4, 7.2) This deficient practice could affect the safety of all (26) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 5/23/18, observations and staff interview revealed the following: Found storage in stairwell by zone 2E and room 2218. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 225	Storage in stairwell was removed by zone 2E and room 2218 was removed on 5/23/18 by Hob Haynes, Maintenance Staff. Housekeeping, Maintenance, Laundry and Nursing have been educated that this is not a storage space. It will be monitored weekly by Maintenance, Items will be removed and audit results reported to Safety Committee, Quarterly. Any changes or education necessary will be determined.	7/2/18
K 363	Corridor - Doors	K 363		7/2/18

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K 363 SS=F	Continued From page 3 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,	K 363		

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K 363	Continued From page 4 etc. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485) This deficient practice could affect the safety of all (18) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 5/23/18, observations and staff interview revealed, or observation and documentation reviewed revealed the following: Observation during the inspection found rated doors did not close with tested at Kitchen, and the Soiled linen by 118 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363	Door on 218 was adjusted and closes properly on 5/23/18, by Bob Haynes. All door closures will be check for proper closure during fire drills. Any doors observed not working properly will generate a work order and be repaired. Fire door repairs will be monitored by the Maintenance Department Director or Designee, and reported to the Safety Committee to track any trends or issues.	
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.	K 372		7/2/18

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K 372	Continued From page 5 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: The facility failed to comply with Life Safety Code (19.3.7.3, 8.6.7.1(1) This deficient practice could affect the safety of all (130) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 5/23/18, observations and staff interview revealed the following: Found penetrations in smoke barrier located at 1E,1F,2E,1G wings of the building. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372	penetrations in smoke barrier located on 1E, 1F, 2E, 1G have been sealed with 3M fire barrier sealant by Bob Haynes on 6/14/18. Any future contractors or workers working on smoke barrier walls or areas will have a contract written stating they understand State Fire codes and will include sealing of any penetrations. Inspection of the work will be completed by the Maintenance Director to ensure compliance.	
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 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	K 918		7/2/18

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K 918	Continued From page 6 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: The facility failed to comply with Life Safety Code (6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)) This deficient practice could affect the safety of all (130) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 5/23/18, observation and documentation reviewed revealed the following: This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918	Generator stop switch will be installed on 6/21/18, by retro-fit company. Need copy of the load bank test report for Generator#2. Generator #1 overheated and the following attached service repair quote will fix the issue. once the repair is completed load test bank report will be forwarded to the Fire Marshal. Premier Critical Power will be conducting full load test on an annual basis.	