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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YWER

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00891

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245479**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY RESIDENCE ON HUMBOLDT**
(L4) **514 HUMBOLDT AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55107**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/16/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **04** (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)
06/30

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

12.Total Facility Beds **30** (L18)
13.Total Certified Beds **30** (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
30				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Beth Lacina, HFE NE II — 05/16/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/19/2017 (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
09/30/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/21/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/26/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245479
June 14, 2017

Mr. Michael Syltie, Administrator
Cerenity Residence on Humboldt
514 Humboldt Avenue
Saint Paul, MN 55107

Dear Mr. Syltie:

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 May 16, 2017 the above facility is certified for or recommended for:

30 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2017

Mr. Michael Syltie, Administrator
Cerenity Residence on Humboldt
514 Humboldt Avenue
Saint Paul, MN 55107

RE: Project Number #S5479028
Dear Mr. Syltie:

On April 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 23, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 16, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 16, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 23, 2017, effective May 16, 2017 and therefore remedies outlined in our letter to you dated April 7, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245479 Y1	A. Building B. Wing Y2	5/16/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0253	Correction	ID Prefix	F0280	Correction	ID Prefix	F0309	Correction
Reg. #	483.10(i)(2)	Completed	Reg. #	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. #	483.24, 483.25(k)(l)	Completed
LSC		05/02/2017	LSC		05/16/2017	LSC		05/16/2017
ID Prefix	F0371	Correction	ID Prefix	F0465	Correction	ID Prefix		Correction
Reg. #	483.60(i)(1)-(3)	Completed	Reg. #	483.90(i)(5)	Completed	Reg. #		Completed
LSC		05/16/2017	LSC		05/16/2017	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/23/2017	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YWER

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00891

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(L1) **245479**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY RESIDENCE ON HUMBOLDT**
(L4) **514 HUMBOLDT AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55107**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/23/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **04** (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)
06/30

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

12.Total Facility Beds **30** (L18)
13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
30				
(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 :
Cynthia Wentkiewicz, HFE NE II 04/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 04/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
09/30/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/26/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 7, 2017

Mr. Michael Syltie, Administrator
Cerenity Residence on Humboldt
514 Humboldt Avenue
Saint Paul, MN 55107

RE: Project Number S5479028, H5479024, H5479025 & H5479026

Dear Mr. Syltie:

On March 23, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 23, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5479024, H5479025 & H5479026 that were found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 2, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 June 23, 2017 (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 September 23, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245479	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted March 20, 21, 22, and 23, 2017. 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. Electronic submission of the POC 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. At the time of the survey, an investigation of complaints #H5479024, H5479025 and H5479026 were completed and found to be unsubstantiated.	F 000		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility did not ensure windows were clean for 3 of 6 residents (R170, R164, R168) who stated the windows in their rooms were blurry and not clean. Findings include: Observations were made during stage I on 3/20/17-3/21/17; and on 3/22/17, from 7:30-7:47 a.m.	F 253	F253: The facility has policies and procedures in place to ensure there are housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The windows in rooms 413, 419, and 439 will have the window covering film removed according to an established schedule of 2 windows per month. The Assistant Administrator or designee will be responsible for compliance. Progress reports on the completion	5/2/17

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

Electronically Signed | 04/13/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245479	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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 253	Continued From page 1 In rooms 413, 419 and 439 the windows contained film coverings, which caused the view to be obscurred. A small edge (1-2 centimeters) around the window coverings was viewable and had an unobscurred view. On 3/22/17, at 7:30 a.m. nursing assistant (NA-A) stated the facility took the film off some of the windows, but didn't get to "all of them." On 3/22/17, at 7:47 a.m. R170 stated some of the window was clear and some wasn't, and it seemed like there was a plastic film on the windows; at 8:33 a.m. R164 stated the windows could be cleaned and the windows were "kinda hazy." On 3/23/17, at 9:02 R168 stated the view out the window wasn't very clear. On 3/22/17, at 10:30 a.m. the administrator stated the board had only approved removing the film from the windows in the rooms cited during last year's survey, ending 4/8/16. The administrator stated the film coverings were on the inside of the windows and required a razor blade to remove the film. The facility's 8/15 policy titled Environmental Services policy read: 1. Outer pane window washing will be completed by contracted company on an as needed basis. 2. Inner pane window washing will be completed by the facility housekeeping department on weekly basis and as needed. The administrator stated on 3/23/17, at 12:45 p.m. the 8/15, policy was the same as the previous year and had not been revised.	F 253	schedule will be presented to the Quality Council. Compliance date: May 2, 2017	

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	245479	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		5/2/17

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F 280	Continued From page 3 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 280		

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to revise the care plan with changes for 1 of 2 residents (R53) reviewed for urinary catheter use. Findings include: Review of progress notes revealed the physician assessed R53 on 3/14/17, and verbally instructed staff to insert a Foley catheter (indwelling flexible tube passed through the urethra and into the bladder), and accurately record fluid intake and urine output. During an interview on 3/22/17, at 2:33 p.m. the Director of Nursing (DON) confirmed R53 continued to use a Foley catheter for staff to monitor urine output. The DON said the resident came to the facility from the hospital, where R53 had been on aggressive diuretics because of fluid overload. After admit to the facility, the DON said that facility staff thought R53's urine output had decreased, but output was difficult to measure because R53 wore absorbent incontinence products. The DON explained that after laboratory test results suggested dehydration, the physician started R53 on intravenous fluids, and ordered a Foley catheter for accurate urine output monitoring. R53's care plan, dated 2/26/17, had a section for toileting. The toileting section of the care plan described R53 to be incontinent of bladder, but did not specify the use of a Foley catheter. Review of the nursing assistant care card, dated 3/23/17, did not provide any information about the catheter, and instead described R53 as using a	F 280	F280: The facility has policies and procedures in place to ensure that an individual resident has the right to □ unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state □ participate in planning care and treatment or changes in care and treatment. Licensed staff has updated the care plans and care cards per therapy recommendations on all current residents within the TCU, resident R53 has discharged from the facility. All care plans have been reviewed in IDT and are revised appropriately according to current resident status per therapy and provider recommendation. Care Plan policy-Preliminary has been reviewed and revised as appropriate. Documented education will be provided for all licensed nursing personnel to ensure understanding of the care plan and care card updating process. The Care Plan policy will be reviewed during education sessions offered on 4/18/2017 and 4/20/2017. All new licensed staff will receive education regarding care plans and care cards and the process of updating them during their orientation. Care Cards and Care Plans will be reviewed on a weekly basis and with any change with the client by the IDT members to ensure accuracy. DON or designee will ensure and monitor	

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F 280	Continued From page 5 bed pan for toileting. During an interview on 3/23/17, at 11:44 a.m., when asked where the care plan should specify use of the catheter, the DON pointed to a Special Interventions section on the nursing assistant care card saying, "It would normally be here on the care sheet" and called the missing information "an oversight." Facility staff updated the care card daily, according to the DON, who said she would update R53's care card to include catheter use. On 3/23/17, at 21:21 p.m., when asked for a facility policy about updating the care plan, the DON said the facility currently did not have a procedure for that. She said there had been recent staff turnover, so she was trying to figure out a system of reviewing and updating the care plan, and would write a procedure after developing a process that worked.	F 280	compliance. Daily audits Monday - Friday will be conducted x1 week; then 3 audits per week x1 week; then 1 audit per week x1 week; then 2 audits per month x1 month and then review audits monthly at Quality Council. Analysis of the audits and the facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis. Compliance date: May 2nd, 2017.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 309		5/2/17

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F 309	Continued From page 6 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to provide necessary positioning as assessed by the therapy department to attain highest practicable physical well-being for 1 of 1 resident (R53) reviewed for positioning. Findings include: During observation on 3/21/17, at 12:17 p.m. R53 sat with upper body slightly reclined in a wheelchair next to the nurses' station. The wheelchair had a high back and headrest, and one long footrest for both feet to rest upon. R53 leaned to one side in the chair, and wore gripper socks with both feet up on the wheelchair footrest. A nurse removed R53's socks to	F 309	F309: The facility has policies and procedures in place to ensure that an individual resident receives the necessary care and services provided by the facility to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Positioning Policy has been reviewed and is appropriate. Documented education will be provided to all staff providing direct resident on the policies regarding resident positioning/repositioning. Resident R53 has discharged from the facility and we have no specialty wheelchairs at this time.	

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F 309	Continued From page 7 examine the resident's heels. After putting the socks back on, and setting feet back on the footrest, R53's feet slid down toward the back of the footrest, looking like they could slide off the footrest and fall in the space between the back of the footrest and the seat of the wheelchair. During observation on 3/22/17, at 8:16 a.m. nursing assistant (NA)-B provided morning care to R53 after transferring R53 into the wheelchair using a full body mechanical lift. NA-B struggled to place R53's feet on the wheelchair footrest so that they would stay. R53's feet slid off the back of the footrest and fell into the space between the footrest and wheelchair seat. NA-B picked up and placed R53's left foot on the footrest, then picked up and tried to place the right foot two times. Each time it fell off the back of the footrest. NA-B confirmed that this happened often, and wedged a pillow behind R53's feet in an attempt to keep them in place on the footrest. In an interview on 3/22/17, at 9:20 a.m. registered nurse (RN)-A said R53's wheelchair came from therapy, and could recline. During the interview, R53 sat with upper body reclined in the wheelchair next to the nurses' station. R53's feet slid out of the gripper socks and off the back of the footrest. RN-A explained that staff placed pillows behind R53's calves to try to keep R53's feet on the footrest, but said the new wheelchair did not seem to be fitting the resident very well. On 3/22/17, at 9:41 a.m. R53 remained seated in the wheelchair by the nurses' station. Staff stopped to check on the resident's comfort, and said, "Let me reposition you, get some of this weight off your bottom." The staff tilted R53 back in the wheelchair, reclining both the upper and	F 309	Documented education will be provided to all staff providing direct patient care on the on the policies regarding resident positioning/repositioning. The updated policies will be reviewed during the education sessions. Documented education will be provided on positioning a resident in any chair that is not a standard wheelchair to all nursing staff providing direct patient when one is utilized in the TCU. Documented education will be provided on positioning a resident in a standard wheel chair to all nursing staff providing direct patient care. DON or designee and/or therapy will ensure and monitor compliance. Daily audits on standard wheel chair positioning Monday - Friday will be conducted x1 week; then 3 audits per week x1 week; then 1 audit per week x1 week; then 2 audits per month x1 month and then review audits monthly at Quality Council. Analysis of the audits and the facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going monitoring/auditing after analysis. Audits will be conducted on the above schedule when a non-standard wheel chair is being utilized in the facility. Compliance date: May 2nd, 2017.	

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F 309	Continued From page 8	F 309		

lower body, so that the resident's entire body was cradled, with head and knees elevated. R53 faced up toward the ceiling.

In an interview on 3/22/17, at 9:46 a.m. the rehabilitation director explained how in a typical wheelchair, R53 leaned to one side, which caused concern about safety and falling. She said therapy chose this wheelchair so that it could recline (lean the upper body back) and also fully tilt (the entire chair, including footrest, tilts back to cradle and relieve some pressure, minimize falling).

On 3/22/17, at 12:47 p.m. family member (FM)-F wheeled R53 from the dining room toward the resident's room after lunch. FM-F said, "I hate this chair" and commented how staff "did the best they could, but look," and pointed to R53's feet. R53's feet sat on a pillow on top of the footrest, and had partially slid out of the gripper socks. Once in the resident's room, FM-F said, "[R53] keeps trying to push up in [the] chair. I don't think [R53] is comfortable in that chair." R53 leaned on one armrest with a furrowed brow, and attempted to adjust lower body position in the chair. When R53 was unable to reposition self in the chair, FM-F left the room to find a nurse who could lay R53 down in bed for comfort.

In an interview on 3/23/17, at 10:29 a.m. occupational therapist (OT)-E said when R53 was in the chair, the chair should be tilted. OT-E clarified that when R53 was tilted in the chair, the resident's feet stayed properly placed on the footrest. When the chair was just reclined, however, R53 "doesn't have the trunk strength to stay seated in the chair." OT-E explained that when reclined, rather than tilted, R53's hips sink,

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F 309	Continued From page 9	F 309		

and more pressure is put on the coccyx. OT-E said there was a sign up in the resident's room to keep the chair tilted so that R53's hips stay centered when in the chair. OT-E explained that 20-30 degree tilt was appropriate, and anything more than that meant R53 would be looking at the ceiling and unable to engage with the environment. OT-E thought the chair had been in use for about two weeks.

On 3/23/17, at 11:16 a.m. NA-B did not recall receiving training on how to position R53 in the chair.
Review of occupational therapy treatment notes revealed R53 received the wheelchair on 3/15/17. The note described positioning R53 in approximately 20 degree recline with the elevated footplate to prevent sliding, and recommended tilt versus recline.

R53's care plan, dated 2/26/17, failed to provide requirements for positioning R53 in the wheelchair, and did not specify how often R53 was to be repositioned or offloaded. The nursing assistant care card, dated 3/23/17, did not specify proper positioning in the wheelchair.

Review of the Skin Risk Assessment, dated 3/4/17, revealed R53 did not have pressure ulcers at that time, but was at moderate risk "for pressure sore or skin breakdown."

Review of an Event Report, dated 3/22/17, revealed a "small opening on coccyx." RN-A described the skin impairment as an "abrasion" measuring 1 x 0.5 inches, with the surrounding tissue intact. On the report, RN-A checked the following applicable treatments: pressure reducing device for chair; turning/repositioning

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F 309	Continued From page 10 program; applications of ointments/medications. On 3/23/17, at 11:47 a.m., when asked, the DON said R53 had not received a turning and repositioning observation. When asked about the wheelchair positioning, and the new wound on R53's coccyx, the DON noted a progress note which did not mention an open area, but described the skin defect as a small, reddened area. The DON said she had not seen the area yet, and that she would have to go look at it to know more, and to determine if the coccyx area was reddened, or open.	F 309		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other	F 371		5/2/17

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F 371	Continued From page 11 visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, dietary staff failed to perform appropriate hand hygiene and distribute foods in a sanitary manner. Findings include: During continuous observation on 3/20/17, starting at 4:55 p.m., prep cook (PC)-H was observed in the fourth floor kitchenette, serving food on plates to go out to residents in the dining room and on room trays. With gloved hands, PC-H used utensils to pick up a baked potato from the steam table and dish up potato toppings. Wearing the same gloves, PC-H opened the mini refrigerator and took out a plastic bin of lettuce. PC-H reached into the lettuce bin, and grabbed a handful of lettuce for a salad. Then with the same gloves, PC-H removed a plastic bin of sliced tomato from the mini refrigerator, reached into the bin, picked up a tomato slice with her gloved hand, and added it to the salad. PC-H then used a scoop to add cheese to the potato before bringing the plates out into the dining room for dietary staff to distribute. PC-H returned to the kitchen with the same gloves on, and again grabbed lettuce and tomato from the refrigerated bins with her gloved hands. PC-H opened a cabinet with gloved hands and pulled out a pouch of salad dressing. PC-H brought the plate out into the dining room to be delivered, then returned to the kitchen still wearing the gloves. PC-H dished up lettuce by hand on two more plates, and then pulled a container of ham out of the refrigerator. Using the same gloves, PC-H sliced the ham on	F 371	F371: The facility has policies and procedures in place to ensure that an individual resident has the right to have food stored, prepared, distributed and served to them in accordance with professional standards for food safety. The Cutting Board and Food Safety policies have been reviewed and revised as appropriate. Documented education will be provided to all culinary staff that would be assigned to work in the TCU kitchen on the safe food handling policy and the hand washing and glove use policy. The updated policies and processes will be reviewed during the education sessions 4/20/2017 and 4/21/2017. All new TCU culinary staff will be provided with documented education on safe food handling, hand washing and glove use procedures. Culinary Services Director or designee will ensure and monitor compliance. Twice daily audits Monday - Friday will be conducted x2 weeks; then daily audits Monday - Friday will be conducted x2 weeks; then 3 audits per week x2 weeks; then 1 audit per week x1 week; then 2 audits per month x1 month and then review audits monthly at Quality Council. Analysis of the audits and the facilities compliance will be presented to our Quality Assurance Team who will recommend changes and on-going	

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F 371	Continued From page 12 a cutting board and added it to a salad. PC-H removed the tomato bin from the refrigerator and set it on top of the used cutting board before removing tomato slices by hand, and adding them to the salads. PC-H moved the knife and cutting board next to the dish sink and the food scrap bucket that sat on the counter next to the dish sink. At this time, PC-H removed the gloves, and instead of using the foot pedal to open the lid, used the dirty glove wadded in her hand to lift the lid of the plastic garbage can and dispose of the gloves. PC-H donned new gloves without performing hand hygiene. At 5:19 p.m., PC-H received an order for a room tray that would be eaten at a later time. After preparing the food for the room tray with gloved hands, PC-H brought the covered plate of food out into the dining room where the resident refrigerator was located. PC-H opened the door to the resident refrigerator with gloved hands, and left the plate of food for the resident in the refrigerator. PC-H returned to the kitchenette, and with the same gloves, made a salad by hand without using utensils. At 5:29 p.m. PC-H removed the dirty gloves, and used bare hands to lift the lid of the garbage can and dispose of the gloves. Then without hand hygiene, PC-H donned new gloves. The lid of the garbage can had brownish black residue on the edges, and concentrated on the corners and in the creases of the lid. At 5:33 p.m. dietary aide (DA)-A brought two used plates in the kitchenette from the dining room. DA-A set the plates on top of the cutting board that was used to cut ham earlier. The cutting board was next to the sink and food scraps	F 371	monitoring/auditing after analysis. Compliance date: May 2nd, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245479	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 371	Continued From page 13	F 371		

bucket. One plate at a time, DA-A picked up a plate, and while holding it over the cutting board, scraped the food scraps into the bucket. DA-A then moved the plates into the sink to be rinsed prior to the dishwasher cleaning.

At 5:37 p.m., with gloved hands, PC-H removed a lettuce bin from the refrigerator and dumped the lettuce into the food scraps bucket, tapping the lettuce bin onto the scrap bucket to thoroughly empty the lettuce from the bin. Then with the same gloves, PC-H picked up the same cutting board used to cut ham earlier, which had been sitting next to the sink and scrap bucket, and had dirty plates set on it. PC-H brought the cutting board to the counter area used to prepare salads. PC-H removed the lettuce bin, sliced tomato bin, and a hard boiled egg bin out of the mini refrigerator, and set them down on top of the cutting board. PC-H dished lettuce and sliced tomato onto a plate using gloved hands, then cut ham, cheese, and hard boiled egg on the cutting board. After adding the cut toppings to the salad, PC-H opened a cabinet with gloved hands and removed a pouch of salad dressing. Finally, PC-H used the same gloved hand to hold a baked potato in place while cutting it open, then brought the plates to the dining room.

At 5:56 p.m., observed an undated hand washing policy near the garbage can, above the hand washing sink, that directed staff to wash hands for at least 15 seconds "frequently."

In an interview at 5:59 p.m., PC-H said she usually used utensils to dish up lettuce and tomato for salads, but said today she used all the utensils for the toppings in the baked potato bar. PC-H said she probably should have just

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	245479	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 371	Continued From page 14 changed her gloves after working with each salad. When asked about how frequently hand hygiene should occur, PC-H said she would sometimes grab new gloves when going out into the dining room to hand off the plates. On 3/20/17, at 6:01 p.m. observed the area in the dining room with extra gloves, next to the entrance of the kitchenette. There was no sink for handwashing here. The only handwashing sink in this area was in the kitchenette. PC-H was not observed to wash hands in the kitchenette during the entire observation on 3/20/17 from 4:55 p.m. through 5:59 p.m. On 3/23/17, at 9:41 a.m. the culinary services assistant director said a majority of dietary staff use utensils to touch ready to eat foods, but some preferred to use gloves. She said that using gloves to touch the food was okay, but she expected gloves to be removed when other objects were touched. For example, if staff needed to open up a jar of peanut butter, she expected staff to remove gloves and get a new pair. The assistant director said she expected meats to stay separate from cheese on a cutting board, and thought the kitchenette had multiple cutting boards to use. An undated policy titled Handwashing Procedure directed staff to "wash hands when indicated by accepted professional practice." The policy noted that "hands must be washed frequently, thoroughly and according to proper procedure."	F 371		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		5/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245479	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 465	Continued From page 15 (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility did not ensure room windows were clean in 14 of 30 resident rooms (405, 407, 409, 411, 415, 416, 417, 418, 420, 437, 441, 445, 451, 453); and one family room. Findings include: Observations were made during stage I on 3/20/17-3/21/17; on 3/22/17, from 7:30-7:47 a.m. and on 3/23/17, from 8:30-8:50 a.m. The West facing windows in rooms 405, 407, 409, 411, 415, 417, 437, 441, 445, 451, 453 and the family room had window (film) coverings that were blurry and obscured the outside view. A small edge (1-2 centimeters) around the window coverings was viewable and had an unobscurred view. The window panes in room 416 had white splatter marks on the lower pane. In Room 418 there was a 1 foot by 6 inch grayish smear on the lower pane. In room 420 there were smears on the lower pane, which obstructed the view. On 3/22/17, at 7:30 a.m. nursing assistant (NA)-A stated the facility took the film off some of the	F 465	F465: The facility has policies and procedures in place to ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The windows in rooms 416, 418 and 420 have been cleaned and all other windows have been inspected and cleaned if necessary. An outside contractor has been selected to clean the outside panes of the windows. The windows with the window coverings (rooms 405,407,409,411,415,417,437,441,445,451, 453 and family room) will have the film removed according to an established schedule of two windows per month. The Window Cleaning policy has been reviewed and revised as appropriate. Documented education on the updated policy will be provided to all TCU housekeeping/maintenance staff regarding the cleaning of windows. The Assistant Administrator or designee will be responsible for compliance. Daily	

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	245479	A. BUILDING _____ B. WING _____	C 03/23/2017

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CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 465	Continued From page 16 windows, but didn't get to "all of them." On 3/22/17, at 10:30 a.m. the administrator stated the board had only approved removing the film off the windows in the rooms cited at last year's survey. The condition of the windows in rooms 416 and 418 were reviewed with the administrator. On 3/23/17, at 8:45 a.m. the administrator stated the facility had changes in the maintenance department since the last survey and had attempted to set up a preventative maintenance plan. The administrator stated the assistant administrator was heading up the preventative maintenance plan. When asked the last time the outside windows had been cleaned the administrator thought it may have been three years ago. On 3/23/17, at 9:10 a.m. the assistant administrator (AA) stated they had recognized the problem with the cleanliness of the inside of windows and had developed a plan, which included cleaning the windows when a resident left. The AA stated she did not recall when the plan had been implemented. When asked when the AA had found out the plan was not working the AA stated "today". The AA stated housekeeping was to inform the janitorial staff when a resident left, so the janitorial staff could clean the windows. The AA stated housekeeping staff were not informing janitorial staff. On 3/23/17, at 10:20 a.m. housekeeper/janitor (H/J)-C stated he was currently cleaning windows. He stated about a month ago a new procedure had been developed that when a resident moved out a housekeeper would call him	F 465	audits of windows will be done for one week; then 3 audits per week x one week; then 1 audit per week x one week; and then 2 audits per month x one month will done. Results of the audits will be presented to the Quality Council. Compliance date: May 2, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245479	A. BUILDING _____ B. WING _____	C 03/23/2017

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CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 465	Continued From page 17	F 465		

to clean the windows. He stated housekeeping staff were contacting janitorial staff and the system was working very well.

H/J-C stated the resident in room 418 had just moved out and he was there to clean the windows. When shown the condition of the windows in rooms 418 and 420 H/J-C stated there used to be a film on the windows that had left a residue which may have caused the smears. H/J-C stated the windows were cleaned on the inside during a room turnaround; and if the weather was nice, the outside window was also cleaned. H/J-C stated if the outside temperature was not above 30 degrees then he would not remove the window to clean the outside, as the cleaning agent would just stick to the window. So the outside portion of the windows were not cleaned in the winter.

The facility's 8/15 policy titled Environmental Services policy read:
1. Outer pane window washing will be completed by contracted company on an as needed basis.
2. Inner pane window washing will be completed by the facility housekeeping department on weekly basis and as needed.

The administrator stated on 3/23/17, at 12:45 p.m. the 8/15, policy was the same as the previous year and had not been revised.

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	245479	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	**514 HUMBOLDT AVENUE SAINT PAUL, MN 55107**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cerenity Residence on Humboldt was found to be 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. CERENITY RESIDENCE ON HUMBOLDT is a 4-story building with a full basement. The building was constructed at 2 different times. The original 4 story building was constructed in 1968 and was determined to be of Type II(222) construction. In 1970, a 4 story addition was constructed to the West that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident sleeping rooms that are monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 24 at the time of the survey. Only the 4th floor is covered in this survey. The requirement at 42 CFR Subpart 483.70(a) is MET as evidenced by:	K 000		

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

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.