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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZSWD

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) **1891 FLORENCE 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 **11/03/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
08/31

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

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

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 :
Gloria Derfus, Supervisor 11/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/21/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

REVISED

CMS Certification Number (CCN): 24-5300

Electronically Delivered: November 24, 2014

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1891 Florence Street
White Bear Lake, Minnesota 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 October 26, 2014 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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 3, 2014

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1891 Florence Street
White Bear Lake, Minnesota 55110

RE: Project Number S5300023

Dear Mr. McDonald:

On October 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 25, 2014 that included an investigation of complaint number . 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 November 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 6, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 25, 2014, effective October 26, 2014 and therefore remedies outlined in our letter to you dated October 3, 2014, 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 about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245300	A. Building B. Wing	11/3/2014

Name of Facility	Street Address, City, State, Zip Code
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0178 Reg. # 483.10(n) LSC	Correction Completed 10/28/2014	ID Prefix F0244 Reg. # 483.15(o)(6) LSC	Correction Completed 10/28/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 10/28/2014
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 10/28/2014	ID Prefix F0358 Reg. # 483.30(e) LSC	Correction Completed 10/28/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	11/03/2014	18623	11/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/25/2014			

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

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ID: ZSWD

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(L2) **253342100**

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(L3) **CERENITY CARE CENTER - WHITE BEAR LAKE**
(L4) **1891 FLORENCE STREET**
(L5) **WHITE BEAR LAKE, MN** (L6) **55110**

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

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

6. DATE OF SURVEY **09/25/2014** (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) :

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (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 :
Magdalene Jares, HFE NE II 10/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/15/2014 (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
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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

Electronically Delivered: October 3, 2014

Mr. Patrick McDonald, Administrator
Cerenity Care Center - White Bear Lake
1891 Florence Street
White Bear Lake, Minnesota 55110

RE: Project Number S5300024

Dear Mr. McDonald:

On September 25, 2014, 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.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 November 4, 2014, 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 December 25, 2014 (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 March 25, 2015 (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
Division of Compliance Monitoring
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.

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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 _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the practice of safe medication administration for 1 of 1 resident (R2), who was observed self-administering medication via nebulizer. Findings include: On 9/22/14, at 3:50 p.m. during a random observation as surveyor walked down hallway on Cypress Court, the sound of an ongoing nebulizer was heard coming from R2's room. R2's room door was wide open, where R2 was observed to	F 176	R2 had a Self-administration of Medication Assessment Completed. R2 had care plan reviewed and updated as needed. All residents currently receiving nebulizer treatments will be re-assessed and their care plans updated. The policy and procedure for Self - administration of Medications was reviewed and is current. All Licensed Nursing staff will be	10/6/14

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

Electronically Signed | 10/07/2014

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 _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE 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 176	Continued From page 1 have a face mask on while seated in a wheelchair. Nursing assistant (NA)-A was in the room standing close to R2's wheelchair and was talking to R2. -At 3:52 p.m. NA-A stepped out of R2's room, pushed a blood pressure machine as she walked towards the activities room in Cypress Court. R2 was left alone in room while the nebulizer was still going on. Licensed practical nurse (LPN)-A was observed standing by the medication cart, parked at the hallway near the nurses' station, which was about 15 feet away from R2's room. -At 3:53 p.m. R2 was observed still seated in wheelchair, with a face mask, alone in room and the nebulizer was still on. -At 4:01 p.m. when asked if R2 could safely do own nebulization, LPN-A answered R2 should not be left alone to do own nebulizer treatment. LPN-A hurried to R2's room and verified R2 was alone in room while the nebulizer treatment was ongoing. R2's Resident Admission Record dated 6/21/08, indicated R2 had diagnoses to include cerebrovascular disease, abnormal posture, difficulty walking, hemiplegia (paralysis on one side), dementia, aphasia (loss of ability to understand or express language due to stroke or brain injury), convulsions and depressive disorder. R2's Care Area Assessments (CAAs) dated 4/21/14, indicated R2 had cognitive loss, aphasia and dementia; The CAAs indicated R2 had difficulty making self-understood, was unable to speak, and could only make grunting sounds. The CAAs further indicated, though R2 was able to make use of gestures, R2 was described as "not nodding head appropriately in response to	F 176	re-educated on the Self-Administration of Medication policy and procedure. DON or designee will conduct random audits weekly 1x month then monthly x3 months to ensure compliance to policy/procedure Audits will be reviewed by the QAA committee with action plans to be developed as needed. Correction date 10/26/14	

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 _____	09/25/2014

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F 176	Continued From page 2 questions." R2's quarterly Minimum Data Set (MDS) dated 7/22/14, indicated R2 had moderate cognitive impairment. The Physician Order Report dated 8/25/14 through 9/25/14, directed facility staff to give R2 one vial of ipratropium-albuterol (Duoneb) solution for nebulization four times a day and as needed due to diagnosis of pneumonia or respiratory symptoms. The Physician Orders lacked evdience the resident could self administer the respiratory medication. R2's care plan dated 9/16/14, indicated Duoneb was to be administered "per MD [physician's] order." The care plan lacked evidence the resident wanted to self administer the breathing medication. On 9/25/14, at 2:45 p.m. the director of nursing (DON) stated all residents should be assessed for capability to self-administer medications. The DON added, "If residents cannot self-administer their meds, then they should not be left self-administering their own meds." The facility's policy on Self-Administration of Medications (SAM) dated 12/12, directed staff to assess each resident's mental and physical abilities to determine capability of self-administering medications. The SAM further provided, if a resident was identified as not safe to self-administer medications, "The nursing staff will administer the resident's medications."	F 176		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	F 244		10/6/14

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F 244	Continued From page 3 When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to respond to resident council grievances in a timely manner, this had the ability to affect all residents at the facility that voiced concerns about call lights not being answered in a timely fashion at resident council meetings. Findings include: R136, President of the Resident Council indicated that delay in answering call lights came up quite often at the meetings and gave permission for the surveyors to review the Resident Council meeting minutes. On 7/17/13, the Resident Council meeting minutes were reviewed, the minutes indicate "In attendance for all or part of our meeting:12 residents from the first floor neighborhoods" [the minutes lacked names of who attended] There was no category of old business, "the June minutes were read and approved." "one resident commented on how nice it would be to have lots more nursing assistants". The meeting minutes were signed by the prior director of recreation and the prior administrator. On 8/21/13, the Resident council meeting	F 244	The policy and procedure for Resident Council was reviewed and is current. All Social Workers, Department Heads, and TR staf will be re-educated on the policy and procedure for Resident Council meeting minutes and follow-up. Social Service Director of designee will complete random audits monthly x3 months to ensure compliance to policy and procedure. Audits will be reviewed by the QAA Committee with action plans to be developed as needed. Correction date 10/26/14	

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F 244	Continued From page 4	F 244		

minutes indicated "In attendance for all or part of our meeting were 14 residents from the first floor and one resident from the second floor " [the minutes lacked names of who attended]. "July minutes were read and approved. No old business was pending, the resident had no new concerns to mention". Under the topic of nursing comments included "some of the nursing assistants seem a little rough while using the lift". Under the topic of maintenance "So far, hurray on the new call system being trailed on Cypress Court. Wait times seem to be shorter. Three residents mentioned that clothing seems to be missing from their closets. Under the topic of food services "four residents agreed that it would be nice to get all the components of their meal at once. They report that sometimes they get their cereal but not their mild and have to wait quite some time for the mild, or wait for fruit. Also several residents wondered why items listed on the colored table menus are not available when it comes time to order them. The meeting minutes lacked a response to the voiced concern of "more nursing assistants". and lacked signatures for the director of recreation and the administrator.

On 9/18/13, the Resident council meeting minutes indicated "In attendance for all or part of our meeting were 14 residents from the first floor and three residents from the second floor " [the minutes lacked names of who attended]. "August minutes were read and approved." There was no category of old business. Nursing: "several residents comments that they prefer having the same staff (both nurses and nursing assistants, they specified) at least two days in a row so the staff would be familiar with them, would know what cares and meds they have/like/need, etc." Dietary: " one resident asked if we could check

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F 244	Continued From page 5 past minutes to see if any concerns were still outstanding. [named individual] will check and report at the next meeting." "Two residents one from Oaks and one from Cypress Court mentioned that they felt the server left the area too soon after meals began; it's not always easy to get second helpings once the food is taken back to the kitchen." The meeting minutes were signed by the prior director of recreation and the prior administrator. The meeting minutes lacked a response to the concern of "rough nursing assistants, kitchen staff leaving before seconds can be requested, voiced in August. On 10/16/13, "In attendance for all or part of our meeting were 15 residents from the first floor and 2 residents from the second floor " [the minutes lacked names of who attended]. "September minutes were read and approved." Nursing: Cypress Court residents reported they felt the consistency of staffing was in place, other neighborhoods reported that there was still room for improvement to have the same staff at least two days in a row." "One resident felt it took much too long to wait for an escort to the dining room" [named individual], stated the new neighborhood kitchens would alleviate the concern. A category titled New Business: discussed issues with the new silverware. The meeting minutes were signed by the prior director of recreation and the prior administrator. The meeting minutes lacked a response to the concern kitchen staff leaving before seconds can be requested, and consistent staffing concerns voiced in August and September. On 11/20/13, "In attendance for all or part of our meeting were 12 residents from the first floor and 2 residents from the second floor " [the minutes	F 244		

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F 244	Continued From page 6 lacked names of who attended]. "October minutes were read and approved." Dietary open forum related to culinary concerns: (f) staff leaving the Oaks and Cypress Court dining rooms before residents have a change for second helpings seems to be improving. Discussion of the new silverware" Nursing: only one topic came up ...How long should a shower last?..[named individual] will check with the director of nursing (DON)." A category of Old Business discussed only a Christmas and Food Shelf project. The meeting minutes were signed by the prior director of recreation and the prior administrator. The meeting minutes lacked a response to the concern for delay in transport to meals and consistent staffing concerns, and lack of ability to request second servings at meals voiced in August, September and October. On 12/18/13, "In attendance for all or part of our meeting were 10 residents from the first floor and 1 resident from the second floor " [the minutes lacked names of who attended]. "November minutes were read and approved." A category titled Old Business discussed the silverware samples." The meeting minutes were signed by the prior director of recreation and the prior administrator. The meeting minutes lacked a response to the concern for delay in transport to meals and consistent staffing concerns, and lack of ability to request second servings at meals voiced in August, September and October, and November. On 1/8/14, "In attendance for all or part of our meeting:12 residents from the first floor neighborhoods" [the minutes lacked names of who attended]. There was no category of old	F 244		

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business, "the December minutes were read and approved." Nursing: "One resident noted staff were smoking e-cigarettes in the hallway, could not be specific about what department the staff members represented. Dietary: table 6 indicated everyone comes to use their pot of hot water and there is none left for them, also reported they ask for fruit and milk and don't always get the fruit." The meeting minutes were signed by the prior director of recreation and the prior administrator. The meeting minutes lacked a response to the concern for delay in transport to meals and consistent staffing concerns, and lack of ability to request second servings at meals voiced in August, September and October, and November and the silverware samples from December.

On 2/19/14, "In attendance for all or part of our meeting:11 residents from the first floor neighborhoods" [the minutes lacked names of who attended]. There was no category of old business, "the January minutes were read and approved." Nursing: "One resident commented that more help is needed in the dining room on the first floor. One resident mentioned that they have to wait long for coffee to arrive at the table. On cypress one of the residents mentioned that her call light needs to be looked at, and for nursing it was recommended that they have a float nursing assistant on each neighborhood. The meeting minutes were signed by the recreation coordinator and the prior administrator. The meeting minutes lacked a response to the concern for delay in transport to meals and consistent staffing concerns, and lack of ability to request second servings at meals voiced in August, September and October, and November and the silverware samples from December, and the concerns of the lack of a hot water pot and

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lack of response to food requests during meal time, and staff smoking e-cigarettes in January.

On 3/19/14, "In attendance for all or part of our meeting:14 residents from the first floor neighborhoods and 2 residents from second floor" [the minutes lacked names of who attended]. There was no category of old business, "the February minutes were read and approved." "The issues brought up at the February meeting were addressed and taken care of by staff. Nursing: Call lights on Cypress Court are not getting answered quickly enough-one resident mentioned they need more nursing assistants, one resident was upset and concerned about his dentist appointment being canceled. Maintenance: comments that TV and phones were not working in the new rooms. We suggest that nursing and dietary be invited to the next resident council meeting. The meeting minutes were signed by the recreation coordinators and the prior administrator. The minutes lacked documentation of resolution of specific issues addressed in February, there was no mention if the issues from August through January had been addressed or resolved.

On 4/16/14, "In attendance for all or part of our meeting:10 residents from the first floor neighborhoods and no residents from second floor" [the minutes lacked names of who attended]. There was no category of old business, "the March minutes were read and approved." "one resident wondered why the dentist has not been scheduled yet and would like us to find out what was going on with those appointments." One resident mentioned that he has no working phone in his room, and has been without a phone for about a month. One resident

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F 244	Continued From page 9 mentioned that call lights are still not being answered very quickly on Cypress Court "taking to long to get help". The meeting minutes were signed by the recreation coordinators and the prior administrator. The minutes lacked documentation of resolution of specific issues addressed in February, there was no mention if the issues from August through January had been addressed or resolved. The minutes lacked documentation of response to issues identified in March of phones, TV's not working, taking to long to respond to call lights on Cypress Court, and dental appointment cancellations, and lack documentation of a response/representative from nursing or dietary at the meeting. On 5/21/14, 12 [named] residents were in attendance. The May [sic] minutes were read and approved and seconded." In the category of old business, "one (named) resident stated the dentist issue has been resolved. One (named) resident stated the phone is working. Two residents stated call lights are not answered, it takes a long time for help from the nurse. New Business: two residents mentioned that call lights need to be answered more quickly, "we said we would check with nursing about that issue. " One resident noted that her roommate needs a lot of staff attention and staff was loud and it woke her up. One resident wandered why his door could not be open at night. Discussion about a gift shop and items for sale was had. The meeting minutes were signed by the recreation coordinators and the prior administrator. The minutes lacked documentation of a response or representatives from nursing or dietary. On 6/18/14, 17 [named] residents from two floors were in attendance. The minutes from the last	F 244		

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meeting were read and approved and seconded by named residents." One resident stated call light response was still takes a while to get help, one resident stated they need to answer the call lights more quickly. Residents asked about the gift shop again and recreation coordinator (RC)-1 stated she would ask about it and report back at the next resident council. The meeting minutes were signed by the recreation coordinators and the prior administrator. The minutes lacked documentation of a response or representatives from nursing or dietary.

On 7/16/14, "In attendance for all or part of our meeting:13 residents from the first floor neighborhoods and one residents from second floor" [the minutes lacked names of who attended]. The June minutes were read and approved and seconded." Old business: call lights are still not answered very quickly, "we will bring that issue to the new DON. Nursing: call lights taking a long time to answer. The gift shop was looking for volunteers to run it. The meeting minutes were signed by the recreation coordinators and the prior administrator. The minutes lacked documentation of a response or representatives from nursing or dietary.

On 8/20/14, "In attendance for all or part of our meeting:15 residents from the first floor neighborhoods and no residents from second floor" [the minutes lacked names of who attended]. The July minutes were read and approved and seconded." Old business: call lights are still taking too long to answer, one resident asked if we could hire nursing assistants who are floaters, "we mentioned we would will let the DON know about this issue and suggestion. Nursing: call lights taking a long time to answer. Dietary:

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F 244	Continued From page 11 the food is cold at meals The meeting minutes were signed by the recreation coordinators and the prior administrator. The minutes lacked documentation of a response or representatives from nursing or dietary. On 9/17/14, "In attendance for all or part of our meeting:12 residents from the first floor neighborhoods and no residents from second floor" [the minutes lacked names of who attended]. The August minutes were read and approved and seconded." New Concerns: "we mentioned we would invite the new DON and the new Administrator to the next resident council meeting in October. The meeting minutes were signed by the recreation coordinators and the new administrator. The minutes lacked documentation of a response or representatives from nursing or dietary. RC-1 was interviewed on 9/25/14, at 2:45 and stated the recreation director left last year, and she and another RC have been filling in. RC-1 stated they had not received training, but new that old business should be addressed to respond to grievances and stated; RC-1 stated she was talking about old business with the resident's, but she didn't know why that was being left out of the minutes. RC-1 stated I should probably be reading them better before I sign them. RC-1 knew the call lights had been addressed in October because there had been an email discussing it. RC-1 stated she would expect grievances brought up at the meeting to be addressed, I should probably send out a notice of when and where the meetings are being held. We need to be able to give follow-ups from the departments on what has been brought up. RC-1 verified with RC-2 that she does not save the	F 244		

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F 244	Continued From page 12 original meeting minutes after they are typed up, and stated RC-2 said she did go to the DON and the nursing staff on the floor, we didn't have any training and don't have a boss; the prior administrator should have been reading them (minutes) and saying "why aren't you following up on these meeting minutes. " On 9/25/14, at 2:37 p.m. the social work director stated she expected once a grievance is brought up in resident council, it would be triaged to the right department head, they should do a grievance form, address it, and ensure resolution and then have the ability to track issues. On 9/25/14, at 3:00 p.m. The new administrator stated, he would expect any issues identified at the resident council meeting brought forward, discussed at management meeting and addressed at Resident council meetings. The administrator started 7 days ago, and had not had issues brought forward. On 9/25/14, at 3:16 p.m. the DON stated "any resident council issues regarding nursing should be brought to me and I would address it, or ask to be invited to the meeting. I have been here since July and not been invited yet." The (undated)Concerns, Grievances policy indicated "the facility assures a prompt response by the facility to acknowledge the receipt of a concern, investigate, seek a resolution, and keep the resident appropriately apprised of the progress towards resolution.	F 244		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		10/6/14

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F 282	Continued From page 13 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nebulizer treatment was safely administered to 1 of 1 resident observed resident (R2) according to the care plan. Findings include: On 9/22/14, at 3:50 p.m. during a random observation as surveyor walked down hallway on Cypress Court, the sound of an ongoing nebulizer was heard coming from R2's room. R2's room door was wide open, where R2 was observed to have a face mask on while seated in a wheelchair. Nursing assistant (NA)-A was in the room standing close to R2's wheelchair and was talking to R2. -At 3:52 p.m. NA-A stepped out of R2's room, pushed a blood pressure machine as she walked towards the activities room in Cypress Court. R2 was left alone in room while the nebulizer was still going on. Licensed practical nurse (LPN)-A was observed standing by the medication cart, parked at the hallway near the nurses' station, which was about 15 feet away from R2's room. -At 3:53 p.m. R2 was observed still seated in wheelchair, with a face mask, alone in room and the nebulizer was still on. -At 4:01 p.m. when asked if R2 could safely do own nebulization, LPN-A answered R2 should not be left alone to do own nebulizer treatment. LPN-A hurried to R2's room and verified R2 was	F 282	R2 had Self-administration of Medication assessment completed. R2 had care plan reviewed and updated as needed. The policy and procedure for self-administration of Medication was reviewed and is current. All Licensed Nursing staff will be re-educated on the Self -Administration of Medication policy. All residents currently receiving nebulizer treatments will be re-assesed and their care plans updated. DON or designee will conduct random audits weekly x1 month then monthly x3 months to wnsure compliance to policy/procedure Audits will be reviewed by QAA Committee with action plans to be developed as needed. Correction Date 10/26/14	

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 _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE 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 282	Continued From page 14 alone in room while the nebulizer treatment was ongoing. R2's Resident Admission Record dated 6/21/08, indicated R2 had diagnoses to include cerebrovascular disease, abnormal posture, difficulty walking, hemiplegia (paralysis on one side), dementia, aphasia (loss of ability to understand or express language due to stroke or brain injury), convulsions and depressive disorder. R2's Care Area Assessments (CAAs) dated 4/21/14, indicated R2 had cognitive loss, aphasia and dementia; The CAAs indicated R2 had difficulty making self-understood, was unable to speak, and could only make grunting sounds. The CAAs further indicated, though R2 was able to make use of gestures, R2 was described as "not nodding head appropriately in response to questions." The Physician Order Report dated 8/25/14 through 9/25/14, directed facility staff to give R2 one vial of ipratropium-albuterol (Duoneb) solution for nebulization four times a day and as needed due to diagnosis of pneumonia or respiratory symptoms. R2's care plan dated 9/16/14, indicated Duoneb was to be administered "per MD [physician's] order." The care plan lacked evidence the resident wanted to self administer the breathing medication. On 9/25/14, at 2:45 p.m. the director of nursing (DON) stated that all residents should be assessed for capability to self-administer medications. The DON added, "if residents	F 282		

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	245300	A. BUILDING _____ B. WING _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110

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F 282	Continued From page 15 cannot self-administer their meds, then they should not be left self-administering their own meds."	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Risperdal (Anti-psychotic medication) had an adequate monitoring and failed to monitor effectiveness of	F 329	Orthostatic Blood Pressures were obtained for R164 Orthostatic Blood Pressures were	10/6/14

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	245300	A. BUILDING _____ B. WING _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

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F 329	Continued From page 16 non-pharmacological interventions for 1 of 5 residents (R164) reviewed for unnecessary medications. Findings include: On 9/24/14, at 7:10 a.m. R164 was observed lying in bed eyes closed on her back, lights out in room, with the door slightly open; call light noted sitting on top on the beddings to R164 right side. -At 8:30 a.m. R164 was still observed to be asleep door slightly open. -At 9:35 a.m. R164 was observed all dressed seated at the television (TV) area across from the nursing station. R164 was observed drinking coffee and eating a piece of toast as she was watching TV. When R164 was approached for an interview, R164 stated she had slept well but indicated she needed to go home as she did not live at the facility. When asked if she needed to call her son she indicated the son would be coming later that day. "You know they don't tell me anything and they never told me I live here now." R164 continued having her coffee as she watched TV. -At 9:38 a.m. activities staff approached R164 asked her if she would like to come to current events and exercise and R164 stated she would like to come but needed a little time to finish her coffee. R164's diagnoses included anxiety disorder, dementia with psychosis, myopathy and non-organic psychosis obtained from the undated Resident Admission Record. The Physician's Order dated 5/29/14, indicated R164 received Risperdal 0.25 milligrams (mg) twice daily for dementia with psychosis and Ativan	F 329	obtained for all residents per policy. The policy and procedure for Orthostatic Blood Pressure monitoring was reviewed and is current. The policy and procedure for psychopharmacological medication use including the documentation on non-pharmacological approaches has been updated. All licensed staff will be re-educated on the policy and procedures for psychopharmacological medication use as well as for Orthostatic Blood Pressure monitoring. DON or designee will be responsible for the random auditing psychotropic medication administration per facility policy as well as Orthostatic blood pressure monitoring per facility policy. Audits will be completed weekly x 1 month the monthly x 3 months. Audits will be reviewed by the QAA Committee with action plans to be developed as needed. Correction date 10/26/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

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F 329	Continued From page 17 (anti-anxiety) 0.5 mg every six hours as needed for anxiety with verbal aggression. R164's quarterly Minimum Data Set (MDS) dated 6/17/14, indicated R164 received antipsychotic medication daily and had no behaviors exhibited. The Care Area Assessment (CAA) dated 9/17/13, indicated R164 used psychotropic medications and directed staff to observe for side effects. The psychotropic medication care plan dated 9/17/14, identified R164 received psychotropic medications related to delusional beliefs and diagnosis of anxiety with verbal aggression and dementia. The care plan directed staff to attempt non-pharmacological interventions and monitor for side effects, effectiveness and adverse consequences. In addition neither the CAA nor the care plan had indicated monthly orthostatic blood pressures were to be completed due to R164 using an antipsychotic. Consultation Report dated 7/29/14, indicated "Resident receives Risperdal a medication which may cause orthostasis. An order for monthly or orthostatic blood pressure assessments is not located in orders. Please implement monitoring." Additionally, the report indicated the consultant pharmacist had identified R164 had received Ativan but there was no documentation of non-drug interventions before medication was used as needed and had recommended the facility to ensure documentation of non-drug interventions attempted and outcome before medication. The form was signed and dated 8/1/14, by registered nurse (RN)-A. Review of both the electronic Treatment Administration Record (ETAR's) and electronic Medication Administration Record (EMAR's)	F 329		

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	245300	A. BUILDING _____ B. WING _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

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F 329	Continued From page 18 dated August 2014 through 9/24/14, revealed R164's had an order to check orthostatic blood pressures monthly on the 1st and R164 had received one dose of Ativan as needed on 9/6/14. During further document review, it was revealed R164 orthostatic blood pressure had not been completed for two consecutive months since the consultant pharmacist recommendation had been signed by RN-A for the months of August and September and no non-pharmacological interventions and effectiveness had been tried prior administering medication for R164's anxiety. On 9/24/14, at 9:57 a.m. RN-A reviewed the EMAR and ETAR verified R164 had an order to monitor orthostatic blood pressure and after reviewing the vital signs records she also verified no orthostatic blood pressures had been completed. RN-A indicated she was going to have the administration assistant also assist to look through to verify. -At 10:10 a.m. the administration assistant run the vital signs report and verified again no orthostatic blood pressures had been done. -At 10:32 a.m. RN-A stated her expectation was that the nurses and the trained medication aides (TMAs) were supposed to have done the orthostatic blood pressures as ordered and if the staff were not able to do it they were supposed to have written a progress note with reason for not being able to do it and report it to another shift to attempt to obtain the blood pressures if R164 was unavailable. In addition RN-A indicated the nurses were supposed to document in the progress notes what non-pharmacological interventions had been tired before administering Ativan to R164. RN-A further stated "I don't go looking at every single order that I have put in as I expect that the nurses are responsible to do what they	F 329		

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 _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

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F 329	Continued From page 19 are supposed to do." On 9/24/14, at 10:52 a.m. the director of nursing (DON) stated she expected the nurses to document non-pharmacological interventions used before administering as needed medications and she expected orthostatic blood pressures to be done at least monthly. When interviewed on 9/25/14, at 12:54 p.m. the consultant pharmacist (CP) verified after going through R164 progress notes that R164 had received Ativan on 9/6/14, but no non-pharmacological interventions had documented prior to administering the medication. CP indicated once she had made the recommendation and seen the facility had addressed the concern she usually would go back later to see if it had been done during the next review. CP further stated nurses were supposed to do a nurses note with interventions used before the medication and orthostatic blood pressures were supposed to be done periodically according to the regulation but needed to be done according to the standards of practice which is monthly. On 9/25/14, 2:32 p.m. the nurse practitioner was telephoned but no call back. Psychopharmacological Medication Use policy revised 1/1/13, indicated the facility should comply with the psychopharmacologic dosage guidelines created by the Centers for Medicare and Medicaid Service. The policy lacked direction regarding on going side effect monitoring of orthostatic blood pressure for anti-psychotropic medications and who was responsible to ensure the monitoring was being completed per	F 329		

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	245300	A. BUILDING _____ B. WING _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE STREET WHITE BEAR LAKE, MN 55110**

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F 329	Continued From page 20 regulation and staff were to use non-pharmacological interventions prior to administering medications.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356		10/6/14

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 _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1891 FLORENCE 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 356	Continued From page 21 by: Based on observation and interview, the facility failed to retain the daily posted nurse staffing data for the last three months. This had the potential to effect all 136 residents who resided in the facility, and family/visitors who came to the facility. Findings include: The staff posting was observed on the countertop at the receptionist desk on 9/22/14, at 2:45 p.m. The staff posting was split into two sheets which identified staff ing for the long term care and transitional care units. On 9/25/14, at 10:00 a.m. during an interview with the staffing director (SD), copies of the facility's posted daily nurse staffing forms for the months of 7/14, 8/14 and 9/14 (last three months) were requested for review. However, the SD failed to provide copies of the staff posting as requested. SD admitted not having kept any of the daily staff posting for "about three months now." SD realized mistake and stated having learned lesson to keep the daily nurse staff posting data from then on. The policy was requested for the daily staff postings; however, the facility did not have a policy on how long to keep the daily staff postings.	F 356	The policy and procedure for daily staffing posting was reviewed and updated to include the lenght of retention. The staffing Coordinator will be responsible for the posting of the hours daily and retaining copies per facility policy. DON or Designee will audit the daily posting and retention of the information weekly x 1 month then monthly x3 months. Audits will be reviewed by the QAA Committee with action plans to be developed as needed. Correction Date 10/26/2014	

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

F5300023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY Cerenity Care Center White Bear Lake is a 2-story building with no basement. The building was constructed at 4 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. 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. In 2013, a 2 story addition was constructed to the West. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors 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 136 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms are adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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.

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

F530023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING **02 - CERENITY CC WHITE BEAR LAKE** B. WING _____	**09/23/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY Cerenity Care Center White Bear Lake is a 2-story building with no basement. The building was constructed at 4 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. 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. In 2013, a 2 story addition was constructed to the West. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors 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 136 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms are adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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