

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 9, 2020

Administrator Cerenity Care Center On Humboldt 512 Humboldt Avenue Saint Paul, MN 55107

RE: CCN: 245255 Cycle Start Date: July 31, 2020

Dear Administrator:

On October 20, 2020, we notified you remedies were imposed. On November 7, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 6, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 16, 2020 be discontinued as of November 6, 2020. (42 CFR 488.417 (b))

In our letter of August 17, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 16, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 10, 2020

Administrator Cerenity Care Center On Humboldt 512 Humboldt Avenue Saint Paul, MN 55107

RE: CCN: 245255 Cycle Start Date: July 31, 2020

Dear Administrator:

On August 17, 2020, we informed you of imposed enforcement remedies.

On August 28, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 16, 2020, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 16, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 16, 2020.

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

As we notified you in our letter of August 17, 2020, in accordance with Federal law, as specified in the

Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 16, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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).

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858

> Email: gail.anderson@state.mn.us Phone: (218) 332-5140

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 31, 2021 (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.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

Cerenity Care Center On Humboldt September 10, 2020 Page 4 copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Kumala Fiske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
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	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	on-site revisit of you validate that substa		F 6	609			9/28/20
		onse to allegations of abuse, n, or mistreatment, the facility					
	involving abuse, ne mistreatment, inclu- source and misapp are reported immed	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 09/18/2020

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.

PRINTED: 10/05/2020

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WING 0007 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107 Y CARE CENTER ON HUMBOLDT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S FLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 2 had respiratory failure, heart failure, Diabetes which included bed mobility, toileting, bathing, dressing, grooming and transferred with the use of a mechanical lift. F 609 R3's care plan revised 8/17/20, indicated R3 had a potential alteration in cognitive impairment related to cognitive scores that fluctuated, R3's care plan indicated R3 had a history of refusing cares and reporting rough treatiment by staff. The care plan indicated R3 had a history of refusing cares and reporting rough treatiment by staff. The care fold: related to impaired mobility and required extensive assistance with most ADL's which included bathing, dressing, grooming, indicated R3 did not walk and required the use of a mechanical lift for transfers. F 609 Review of late entry progress note on 3/25/20, at 1.08 p.m. R3 reported to staff she had some care concerns and notifications were completed. F 609 Review of the SAN Jursing Home Incident Report and care in accordance with most ADL's which included bathing, dressing, grooming, indicated R3 did not walk and required the use of a mechanical lift for transfers. F 609 Review of the SAN Jursing Home Incident Report (NHR), revealed the allegation occurred at 3/25/20, at 1:19 a.m. director of nursing (DON) indicated staff wen recore of a manager, Don

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00538

PRINTED: 10/05/2020 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			· · ·	SURVEY PLETED
	245255		B. WING			C 08/28/2020	
NAME OF	IAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER ON	I HUMBOLDT		-	12 HUMBOLDT AVENUE AINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 609	• · · · · · · · · · · · · · · · · · · ·	-	F 6	609			
	to the SA within two was notified of R3's on the day shift on 3 provide an exact tim entry progress note and confirmed the a reported to the SA w On 8/26/20, at 11:5 (NA)-A stated she w p.m. shift on 3/25/2 provided cares to R her she had been b night. NA-A stated s charge nurse worki abuse. NA-A stated of abuse were expe immediately. NA-A cares to R3 betwee most mornings. On 8/26/20, at 12:0 stated she expected to be reported imme and they would file hours. The adminis allegation of abuse hours to the SA. Review of facility po Plan undated instru-	ne of them would file a report o hours. DON stated the facility allegation of abuse sometime 3/25/20, and was not able to ne. DON reviewed R3's late dated 3/25/20, at 1:08 p.m. allegation had not been within the two hour time frame. 2 a.m. nursing assistant vorked the 6:30 a.m. to 3:00 0, and confirmed when she 3 that morning, R3 informed eat up by staff during the she immediately informed the ng that day of the allegation of she was aware all allegations ected to be reported stated she routinely provided in 10:30 a.m. to 11:00 a.m. 1 p.m. the administrator d all allegations of abuse were ediately to LSW or designee the report to the SA within two trator confirmed R3's was not reported within two conficted staff to immediately in of abuse to the person in it to the SA within two hours.			to, examples of types of abuse/exploitation/neglect, who is a mandated reporter, responsibilities of mandated reporter, timeliness of rep and what to do to ensure resident sa Audits will be completed 5 times per for 4 weeks, then 3 times per week weeks, then 2 times per week for 2 to ensure ongoing compliance. The results of these audits will forward to QAPI committee for review and the committee will determine when compliance is indicated. All vulnera adult reports will be audited for 2 mo for timeliness. 100% auditing will co as long as compliance is below 100 The Director of Nursing and/or desig will be responsible for ongoing compliance.	of porting afety. r week for 3 weeks to the ble poths potinue %.	

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 4 of 4



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 10, 2020

Administrator Cerenity Care Center On Humboldt 512 Humboldt Avenue Saint Paul, MN 55107

Re: State Nursing Home Licensing Orders Event ID: ND3511

Dear Administrator:

The above facility was surveyed on August 25, 2020 through August 28, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.u</u>s

Minnesc	ta Department of He	ealth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00538	B. WING		08/2) 8/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE			
512 HUMBOLDT AVENUE							
CERENI	TY CARE CENTER ON		UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon iny item of multi-part rule will ment of a fine even if the item					
	corrected. You may request a that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	INITIAL COMMENT On 8/25/20, to 8/28 was conducted to d licensure. Your faci	·					
	The following comp substantiated:	laints were found to be					
Vinnesota D	epartment of Health						
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 09/18/20	
	isally signed					00/10/20	

STATE FORM

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If continuation sheet 1 of 6

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED C
		00538	B. WING			28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CERENI	TY CARE CENTER ON	HUMBOLDT	IBOLDT AVENI AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	H5255071C with lic	ensing order issued at 1980.				
	signature is not req page of state form. is required, it is requ	ed in ePOC and therefore a uired at the bottom of the first Although no plan of correctior uired that the facility ot of the electronic documents	1			
21980	MN St. Statute 626 Maltreatment of Vul	557 Subd. 3 Reporting - nerable Adults	21980			9/24/20
	reporter who has revulnerable adult is to or who has knowled has sustained a phy reasonably explained information to the c individual is a vulne the individual is adm reporter is not requi	f report. (a) A mandated ason to believe that a being or has been maltreated, lge that a vulnerable adult vsical injury which is not ed shall immediately report the ommon entry point. If an rable adult solely because nitted to a facility, a mandated red to report suspected individual that occurred prior s:				
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above	as admitted to the facility from the reporter has reason to ole adult was maltreated in the nows or has reason to believe a vulnerable adult as defined , subdivision 21, clause (4). required to report under the ection may voluntarily report s section requires a report of				
	known or suspected	d maltreatment, if the reporter n to know that a report has				

Minnesota Department of Health STATE FORM

ND3511

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00538	B. WING		08/28/2020	0
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
CERENI	TY CARE CENTER ON	THUMBOLDI	BOLDT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMP	(5) PLETI ATE
21980	 (d) Nothing in this reporter from also r agency. (e) A mandated r reason to believe th 626.5572, subdivisi (5), occurred must r subdivision. If the r time believes that a agency will determine the reported error with criteria under set 17, paragraph (c), occurred must he criteria the c	s section shall preclude a eporting to a law enforcement eporter who knows or has that an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any n investigation by a lead ne or should determine that vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or	21980			
	directly to the lead a how the event meet 626.5572, subdivisi (5). The lead ager information when m the report under sub					
	by: Based on interview facility failed to ensu- immediately reported the State Agency (S	and document review, the ure allegations of abuse were ed (no later than 2 hours) to GA) for 1 of 3 residents (R3) ions of potential abuse.		Corrected		
	6/30/20, identified F had diagnoses whic Diabetes Mellitus, r The MDS indicated assistance with mos (ADL's) which include	Im Data Set (MDS) dated R3 was cognitively intact and ch included heart failure, espiratory failure and anxiety. R3 required extensive st activities of daily living ded bed mobility, transfers, ressing and grooming.				

Minnesota Department of Health STATE FORM

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ND3511

If continuation sheet 3 of 6

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00538	B. WING	B. WING		28/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
	TY CARE CENTER ON	N HUMBOLDT	IBOLDT AVENU AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From pa	ige 3	21980				
	7/13/20, identified F had respiratory fails Mellitus and anxiety required extensive which included bed	rea assessment (CAA) dated R3 had intact cognition and ure, heart failure, Diabetes y. The CAA identified R3 assistance with most ADL's mobility, toileting, bathing, and transferred with the use					
	a potential alteratio related to cognitive care plan indicated cares and reporting care plan instructed needed, actively inv R3 choices. R3's ca self care deficit rela- required extensive which included bath toileting, and bed m	sed 8/17/20, indicated R3 had n in cognitive impairment scores that fluctuated. R3's R3 had a history of refusing grough treatment by staff. The d staff to provide support as volve R3 in her care and allow are plan identified R3 had a ated to impaired mobility and assistance with most ADL's hing, dressing, grooming, nobility. R3's care plan it walk and required the use of r transfers.					
	1:08 p.m. R3 repor	y progress note on 3/25/20, at ted to staff she had some care cations were completed.					
	A copy of the facility requested and was	y's internal incident report was not provided.					
	(NHIR), revealed th 3/25/20, at 2:00 a.m reported to the SA	lursing Home Incident Report ne allegation occurred at n. and the allegation was on 3/25/20, at 4:34 p.m., 14 allegation had occurred.					
		9 a.m. director of nursing aff were expected to report all					

IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING: _		(X3) DATE SURVE COMPLETED		
		00538	B. WING		08/	28/2020
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ERENI	TY CARE CENTER ON	N HUMBOLDT	BOLDT AVEN AUL, MN 5510			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
21980	Continued From pa	ige 4	21980			
	DON, licensed soci administrator and o to the SA within two was notified of R3's on the day shift on provide an exact tir entry progress note and confirmed the a reported to the SA On 8/26/20, at 11:5 (NA)-A stated she w p.m. shift on 3/25/2 provided cares to R her she had been b night. NA-A stated s charge nurse worki abuse. NA-A stated of abuse were expe immediately. NA-A cares to R3 betwee most mornings. On 8/26/20, at 12:0 stated she expecte to be reported imm and they would file hours. The adminis allegation of abuse hours to the SA. Review of facility po Plan undated instru- report the allegation	e immediately to a manager, al worker (LSW) or the one of them would file a report o hours. DON stated the facility is allegation of abuse sometime 3/25/20, and was not able to ne. DON reviewed R3's late e dated 3/25/20, at 1:08 p.m. allegation had not been within the two hour time frame 2 a.m. nursing assistant worked the 6:30 a.m. to 3:00 0, and confirmed when she 83 that morning, R3 informed beat up by staff during the she immediately informed the ng that day of the allegation of a she was aware all allegations ected to be reported stated she routinely provided en 10:30 a.m. to 11:00 a.m. 11 p.m. the administrator d all allegations of abuse were ediately to LSW or designee the report to the SA within two strator confirmed R3's was not reported within two strator confirmed R3's was not reported within two strator to the person in rt to the SA within two hours.				

ND3511

Minnesc	ota Department of He	alth			FORM	AFFROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00538	B. WING		C 08/2	; 8/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CERENI	TY CARE CENTER ON	IHUMBOLDT	BOLDT AVEI UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
	Continued From pa SUGGESTED MET The Administrator a the facility polices in allegations of mistra unknown origin to t administrator and/c on ensuring reports manner. The admin routinely monitor to in a timely manner.	THOD OF CORRECTION: and/or designee could review n regards to reporting of eatment and/or injuries of he State Agency. The or designee could educate staff are submitted in a timely histrator or designee could ensure reports are submitted			PRIATE	DATE
Minnesota D	epartment of Health					

ND3511