Electronically delivered
June 26, 2019

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

RE: Project Numbers H5300033C, H5300034C

Dear Administrator:

On June 12, 2019, an abbreviated 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. In addition, at the time of the June 12, 2019 abbreviated standard survey the Minnesota Department of Health completed an investigation of complaint number H5300033C that was found to be substantiated and H5300034C that was found to be unsubstantiated.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 31, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 31, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 31, 2019.

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 31, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cerenity Care Center - White Bear Lake will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 31, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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, Licensing and Certification Program staff and 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 December 12, 2019 (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 copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 06/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/12/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5300033C at F760. The following complaint was found not to be substantiated: H5300034C 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 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free of significant medication errors for 2 of 3 residents (R1 and R3) who were reviewed for medication errors.	F 760	F 760 SS=G Free of Significant Med Erros The policies □Administering	7/17/19

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

Electronically Signed | 07/03/2019

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 26, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Numbers H5300033C, H5300034C

Dear Administrator:

A complaint investigation was completed on June 12, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. Please remember that this provision is only a suggestion 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	C 06/12/2019

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 6/12/19, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure. The following complaint was found to be substantiated:	2 000		

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2 000	Continued From page 1 H5300033C was found not to be in compliance at the time of the survey. As a result the following correction orders are issued: 4658.1320. The following complaint was not found to be substantiated: H5300034C was found to be in compliance at the time of the survey. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's	21545		7/17/19

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21545	Continued From page 2 blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free of significant medication errors for 2 of 3 residents (R1 and R3) who were reviewed for medication errors. R1 was harmed when she received an antibiotic medication twice a day, instead of the one time a day as ordered, requiring hospitalization with severe nausea and vomiting. Findings include: R1's quarterly minimum data set (MDS) dated 3/19/19, identified R1 was cognitively intact and	21545	corrected	

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21545	Continued From page 3	21545		

had diagnoses which included: pneumonia, chronic obstructive pulmonary disease (COPD) and gastroesophageal reflux disease (GERD).

R1's care plan revised 2/25/19, identified R1 received medications which placed her at risk for adverse reactions with interventions which included to administer medications per MD (doctor of medicine) orders.

R1's Nurse practioner (NP) progress notes dated 3/18/19, indicated seen for follow up of pneumonia. R1's physical exam identified nosocomial (facility acquired) pneumonia. Orders included to given Rocephin (an injectable antibiotic) with Lidocaine (a numbing agent) for two doses, to perform some laboratory work on Thursday, and to continue the Doxycyline (antibiotic).

R1's NP orders dated 3/20/19, included orders to discontinue the Doxycyline. R1 was to start Levaquin (an antibiotic) 750 mg (milligrams) PO (by mouth) QD (once a day) X (for) 10 days (for pneumonia).

R1's March 2019 medication administration record (MAR) revealed the following: Levaquin 750 mg had been given in the morning on 3/21/10, 3/22/19, 3/23/19, 3/24/19, and 3/25/19. Levaquin 750 mg had also been given in the evening on 3/20/19, 3/21/19, 3/22/19, 3/24/19 and 3/25/19.

R1's progress note dated 3/25/19, at 3:15 p.m. indicated R1 was being sent to hospital for new onset of GERD and recent Levaquin therapy which, "makes her sick." R1's progress note dated 3/25/19, at 11:59 p.m. indicated R1 had

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21545	Continued From page 4 been admitted to the hospital with a diagnoses of nausea and vomiting. R1's Emergency Department Encounter dated 3/25/19, included R1 had presented to the emergency department for evaluation of gastric symptoms including, reflux, nausea, vomiting, back pain and shortness of breath. R1 had been given a GI (gastrointestinal) cocktail and vomited it up. R1 was given water and vomited. Other oral attempts were tried and failed. Plan to admit R1. R1 had worsening reflux (back flow of food, stomach acid and digestive enzymes up into the esophagus) after starting on Levaquin and worsening shortness of breath. R1's biggest concern was reflux and vomiting, with no abdominal pain. EKG (electrocardiogram-test to detect heart attacks and heart rhythm problems) identified no ischemia (restriction of blood supply), troponin (blood test to check for heart damage) was negative and abdominal x-ray was unremarkable. R1 was given Zofran (anti-nausea medication) but was unable to tolerate by mouth. R1 was also administered Reglan (anti-nausea medication) and Pepcid (antacid medication) and was still unable to tolerate anything by mouth. The note included, "Certainly could of been related to Levaquin, as this was started 5 days ago. She was inappropriately dosed 750 mg twice daily for 10 days". R1 completed 5 days. "Given proper dosing is 750 mg once daily for 5 days, I feel this could be stopped." Given she is unable to keep anything by mouth will admit for observation. R1's information obtained included R1 complained of abdominal pain, "very bad reflux" and stated had been vomiting, "120 times a day" which she described as, "spitting up a lot," into a tissue.	21545		

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21545	Continued From page 5 R1's hospital discharge dated 3/27/19, identified R1 was admitted 3/25/19, with principle problem of nausea and vomiting. R1's discharge summary identified in the Summary Of The Hospital Course that R1 had presented with nausea and vomiting. The summary included, "[R1] had recently been treated for pneumonia initially with Doxycycline and Augmentin and then about 5 days ago was switched to Levaquin. [R1] had been getting Levaquin 750 mg twice daily for 5 days and likely this was what triggered her nausea." Discharge orders included orders to stop Levaquin 750 mg tablets. "Stopping Levaquin as she likely had enough of that and had been getting twice as much as would normally be recommended." R1's event report dated 3/27/19, identified medication error of Levaquin began 3/20/19, ended 3/25/19. Error found by hospital staff 3/26/19, and verified by NP. Order entered wrong by nurse, entered Levaquin 750 mg two times per day rather than the one time a day ordered by the NP on 3/20/19. R1 received wrong dose. Adverse drug reaction was identified as gastrointestinal, GERD signs and symptoms, and loss of appetite. R1 was sent to the hospital per NP order. The event report did not include what, if any, actions were taken by the facility to prevent re-occurrence of this type of error. When interviewed on 6/12/19, at 12:55 p.m. registered nurse clinical manager (RN)-A stated R1 had received Levaquin 750 mg twice a day instead of once a day, this resulted in R1 being hospitalized with nausea and vomiting. Staff became aware of the error only once the hospital	21545		

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CERENITY CARE CENTER - WHITE BEAR LAK	1900 WEBBER STREET WHITE BEAR LAKE, MN 55110

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21545	Continued From page 6	21545		

had notified the facility. The Levaquin order had been entered wrong by a nurse. The transcribing nurse was referred to the staff educator. The order was sent to the pharmacy correctly, and the medication was received at the facility with correct instructions on the label. RN-A stated Staff should have caught the error while reading the directions on the label and clarify the order, but did not. Six different staff administered the Levoquin without catching the error. No further education of all staff who pass medications was conducted.

On 6/12/19, at 2:56 p.m. during a phone interview, nurse practitioner (NP)-A indicated she had ordered R1 to receive Levaquin 750 mg everyday for a total of 10 days, but R1 ended up receiving 750 mg twice a day. NP-A stated the error may have contributed to R1's nausea and vomiting. Staff should make sure the orders are correct before giving the medications. NP-A stated she was concerned R1's medication error went through so many people before being discovered at the hospital.

When interviewed via phone on 6/14/19, at 12:50 p.m. R1's family member (FM)-A stated R1 had been hospitalized because she had receive too large of a dosage of medication. FM-A stated R1 had not been able to eat or keep food down prior to going to the hospital and had improved once the antibiotic was stopped.

R3's quarterly MDS dated 5/1/19, identified R3 had moderate cognitive impairment and had diagnoses which included: heart failure and hypertension (high blood pressure).

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	00923	A. BUILDING: _____ B. WING _____	C 06/12/2019

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21545	Continued From page 7 R3's cognitive care plan revised 5/10/19, identified R3 had self deficit with ADLs and required extensive assistance of staff. R3's care plan did not include any heart issues, medications received, or associated interventions. R3's event report dated 4/29/19, identified a medication error. On 4/8/19, a health unit coordinator (HUC) had inadvertently added R3 to a list of inactive residents which discontinued all of the medications R3 was prescribed. A nurse had noticed all of the medications had been discontinued for R3 and reported it to a nurse manager. The HUC was notified and re-instated all of the medications, except for Coreg (a betablocker used for heart failure and hypertension) 6.25 mg BID. The even report indicated the nurse did not verify the medications after the HUC re-instated them. The error was not found until 4/29/19, resulting in 21 days of missed medication. The physician was updated and ordered for blood pressures to be monitored for two weeks. R3's progress note dated 4/29/19, included, "IDT follow up medication error identified it was discovered R3 had not received Coreg as ordered. R3's medications were discontinued then re-instated the same day. HUC had on list to DC (discontinue) as resident not here any more. Writer had verified and discontinued all orders HUC had on list to do so. Discovered by nurse that medications were not in EMAR, so medications were re-instated by the HUC, all except R3's Coreg. Evening nurse reviewed R3's medication orders, except the Coreg. Not until 4/29/19 that medication found not to be	21545		

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21545	Continued From page 8	21545		

re-instated and was omitted from being given to R3. NP was updated and ordered R3's blood pressures to be done for 2 weeks. Reviewing R3's blood pressures, there are highs and lows. Error did not affect R3's abilities or physical status. Family updated and aware of error. New orders per NP to discontinue current Coreg order and new orders for Coreg 6.25 mg 1 tablet orally twice a day. On Monday check a BMP (basic metabolic panel lab draw) for hypertension and HGB (hemoglobin lab draw) for anemia. Update NP in 2 weeks regarding R3's blood pressure readings."
R3's progress note dated 5/13/19, included, the NP was updated on R3's blood pressures with no new orders.

R3's NP progress notes dated 4/29/19, identified R3's current problems included hypertension, with current medications of Losartan (an antihypertensive) 50 mg QD, Lasix (a water pill) 10 mg QOD (every other day) and Coreg 6.25 mg a.m. and 12.5 mg p.m., with Coreg dosage increased by physician on 3/1/19. R3's NP progress notes identified R3's blood pressure was recently 120's-140's/60's-70's. R3's NP progress notes further identified some confusion in Coreg orders traced back to to a transcription error 4/8/19. Only getting Coreg 12.5 mg at HS (hour of sleep). Will split dose so she will be getting 6.25 mg BID. Review in 2 weeks. If needed p.m. dosage as ordered 3/1/19. For now blood pressure checks look fine. Repeat BMP next week.

When interviewed on 6/12/19, at 12:48 p.m. RN-A stated the HUC had accidentally discontinued R3's medications and when caught, forgot to re-instate the Coreg order. The nurse

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21545	Continued From page 9	21545		

coming on duty should have verified all medication orders, but had not. A nurse discovered Coreg on the medication cart on 4/29/19, and discovered it had not been being given.

A voice mail was left for R3's primary care physician on 6/12/19, at 3:17 p.m. No return call was received.

When interviewed via phone on 6/13/19, at 10:06 a.m. R3's family member (FM)-B indicated she had been made aware of R3's medication error, and indicated it had been corrected. FM-B indicated she felt the medication error was handled correctly, but the facility had made it seem like R3 had only missed a day or two of the medication. FM-B indicated she had not been informed the medication was not administered for 21 days correctly.

On 6/12/19, at 1:54 p.m. director of nursing (DON) indicated the usual facility process for medication order transcriptions included either a HUC (health unit coordinator) completing the order or a nurse. If the HUC completed the order transcription, it was always checked by a nurse, but if a nurse transcribed the medication order, it was not reviewed by another nurse. When a new order was received, a copy of the actual order was sent to the pharmacy. Once a medication error was found, the facility investigates to find out the root cause and what corrective action was necessary. After R1's medication error involving Levaquin, they implemented two educational videos to be completed by the person making the error.

When interviewed via phone on 6/12/19, at 3:25

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21545	Continued From page 10	21545		

p.m. pharmacy consultant (PC)-A stated she was new to the facility. She had not met with the DON yet to discuss medication errors and other processes. PC-A was informed of the significant medication errors of R1 and R3. PC-A indicated she was not aware of the order transcription process at the facility, however, the usual order transcription process was if a HUC completed orders, the orders were double checked by a nurse. It is standard practice for any nurse who administered medication to triple check the order with the medication to assure it was accurate. If the medication order did not match the medication instructions on the card, she would expect them to check the resident's health record to check the actual order. PC-A stated when R3 had not received the Coreg medication it could have caused potential hospitalization and heart failure. R1's Levaquin medication error resulted in nausea, vomiting and hospitalization. PC-A indicated with excess Levaquin dosing there was also a risk of tendon rupture and change in glucose (blood sugar).

When interviewed on 6/12/19, at 4:18 p.m. director of nursing (DON) stated she would expect a nurse to double check orders transcribed by a HUC. However, unless the nurse were to print the original orders out, there was no way to verify the original orders after discontinuation and this was not done for R3. With their current system, the nursing staff give the medications according to the resident's EMARs (computerized medication administration record), and was not sure what a better solution could be to prevent another occurrence of incorrect dosing as in R1's case.

A policy on medication administration and order

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21545	Continued From page 11 transcriptions was requested, but not provided. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication administration and medication order transcriptions to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		