

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 11, 2021

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

RE: CCN: 245300

Cycle Start Date: April 14, 2021

Dear Administrator:

On May 4, 2021, we notified you a remedy was imposed. On June 9, 2021 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 May 28, 2021.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective July 14, 2021 did not go into effect. (42 CFR 488.417 (b))

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,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mighing

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 4, 2021

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

RE: CCN: 245300

Cycle Start Date: April 14, 2021

Dear Administrator:

On April 14, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 14, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 14, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 14, 2021.

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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

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 October 14, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

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

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,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 06/07/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		245300	B. WING _		C 04/14/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	V7/ 17/202 I
CERENIT	Y CARE CENTER - W	VHITE REAR I AKE		1900 WEBBER STREET	
CLICLINII	TOAKE CENTER - W	WITE BLAK LAKE		WHITE BEAR LAKE, MN 55110	
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F 000	INITIAL COMMENT	ΓS	F 00	00	
	abbreviated survey Your facility was fou with the requiremen	th 4/14/21, a standard was conducted at your facility. and to be NOT in compliance at sof 42 CFR 483, Subpart B, ong Term Care Facilities.			
	SUBSTANTIATED: * H5300050C (MNC cited at F550, F677	00071656) with deficiencies 7, F686, and F880. 00068525) with deficiencies			
	UNSUBSTANTIATE	plaint was found to be ED: 00071781) with no deficiencies			
		f correction (POC) will serve of compliance upon the otance.			
	signature is not req				
E 550	onsite revisit of you		F 55	50	E/29/24
	CFR(s): 483.10(a)(r 55		5/28/21
	§483.10(a) Resider The resident has a	nt Rights. right to a dignified existence,			
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				05/14/2021

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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F 550	self-determination access to persons outside the facility, this section. §483.10(a)(1) A fa with respect and dresident in a mann promotes mainten her quality of life, rindividuality. The fapromote the rights §483.10(a)(2) The access to quality of severity of condition must establish and practices regarding provision of service residents regardles. §483.10(b) Exercise The resident has the rights as a resident or resident of the Use of interference, coercinterference, coercinterfere	and communication with and and services inside and including those specified in cility must treat each resident ignity and care for each her and in an environment that ance or enhancement of his or recognizing each resident's acility must protect and of the resident. facility must provide equal eare regardless of diagnosis, on, or payment source. A facility dimaintain identical policies and gransfer, discharge, and the es under the State plan for all se of payment source. se of Rights. he right to exercise his or her at of the facility and as a citizen	F 550				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 550	Based on observareview the facility of preferred name for were reviewed for Findings include: R1's admission Minuted Mental Status (Bloom interest cognition with MDS indicated R1 with all activities of R3's admission Minuted a BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted a BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted a BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted a BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted a BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted a BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted a BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure. R14's admission Minuted BIMS of 13, with diagnoses of respiratory failure.	ation, interview, and document failed to call residents by their r 1 of 3 (R1) residents who dignity. Inimum Data Set (MDS) dated R1 had a Brief Interview for MS) score of 15, indicating th a diagnosis of cancer. R1's needed extensive assistance f daily living (ADLs). DS dated 3/23/21, indicated R3 which indicated intact cognition pneumonia and acute MDS dated 4/12/21, indicated of 15, which indicated intact gnoses of trauma and multiple bones). R14's MDS further e assistance with ADLs. W on 4/13/21, at 1:06 p.m. R1 sistant (NA)-B "always" called did not like it. R1 stated she all her "hon" but NA-B ignored 1 told registered nurse (RN)-D ged." ation on 4/14/21, at 8:30 a.m. ed calling R14 "my friend."	F 5	TN an Rth R right and fet to up to a the SFR not be 20 D to not xix print C and the state of the	The policy, Resident Rights an lotification of Resident Rights and deemed appropriate. R1, R3, and R14 have since discine facility. Resident council held on 5/5/21, ghts specific to use of preferred and dignity discussed with reside redback vocalized by residents to IDT team. Facesheets and car pdated as needed based on resouncil feedback. Residents who ttend resident council will be proper resident council minutes by Stervices. Resident Right policy and use of ame as determined by the resident Right policy and use of ame as determined by the resident Council minutes and compliance. Audits of staff using ame will be completed 3 times part of the service and reviewed at Quality resented and reviewed at Quality council, who will recommend chand on-going monitoring/auditing analysis.	reviewed harged resident name nts and provided e plans ident did not vided ocial he preferred ent. This d 21st, monitor preferred er week 3 times be y unges		
	NA-B was observe	ation on 4/14/21, at 8:40 a.m. ed calling R3 "hon." ation on 4/14/21, at 8:45 a.m.						

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F 550	Continued From particles NA-B was observed During an interview stated he called ever man "friend." NA-B permission from the "hon" or "friend" and should not address. During an interview director of nursing (residents by their probationed by social state DON stated some state as a term of endear not like it, they would them if they were used them if they were used CFR(s): 483.24(a)(2) A restruction out activities of daily services to maintain personal and oral house the state of the services to maintain personal and oral house the services the serv	ge 3 I calling R14 "hon." on 4/14/21, at 8:50 a.m. NA-B ery woman "hon" and every stated he did not ask eresidents before calling them dono residents told him he them that way. on 4/14/20, at 4:27 p.m. the DON) stated staff should call referred name, which was services on admission. The staff might call residents "hon" ment, but if the resident did do expect the resident to tell incomfortable with it. for Dependent Residents 2) ident who is unable to carry yoliving receives the necessary in good nutrition, grooming, and	F 55	DEFICIENCY)	5/28/21	
	review the facility facare to 2 of 3 reside provide weekly bath reviewed for assista	iled to to provide incontinence ents (R4 and R5) and failed to as for 1 of 3 residents (R1) ance with activities of daily ed to dependent residents.		was reviewed and deemed appropring R 4 has since discharged the facility R5 s Bowel and Bladder Observativere reviewed and updated as needed based on review of observations.	iate. y. ions ded. as	
	Findings include: INCONTINENCE C	ARE		as well as the nursing assistant can sheet. All residents who require ass two for ADLs, had their Bowel and E	sist of Bladder	
	R4's admission Min	imum Data Set (MDS) dated		assessments and care plans review and updated as need.	/eu	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 677	3/9/21, indicated R Status (BIMS) of 8 impaired cognition and diabetes. R4's always incontinent required assistance. During an observathe doorway of R4'came from the roowent into R4's roomer training (NAT)-A. Nowed was strong, adding the night shift." R4 when he stood up, observed to be sat colored urine and weight of the urine approximately eighunderneath where wet area that smel product was cold to likely worn the wet R4's buttocks, innereddened. NA-A product was cold to likely worn the wet R4's buttocks, innereddened. NA-A product was cold to likely worn the wet R4's buttocks, innereddened. NA-A product was cold to likely worn the wet R4's buttocks, innereddened. NA-A product was cold to likely worn the wet R4's buttocks, innereddened. NA-A product was cold to likely worn the wet R4's buttocks, innereddened. NA-A product was cold to likely worn the wet R4's buttocks, innereddened. NA-A product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to likely worn the wet R4's buttocks, innereddened incontinent product was cold to like	A had a Brief Interview Mental, which indicated moderately and diagnoses of dementia MDS also indicated R4 was of bladder and bowel and e of one person with toileting. Ition on 4/12/21, at 8:45 a.m. in s room, a strong urine smell m. Nursing assistant (NA)-A mile with nursing assistant in IA-A stated the smell of urine g "this happens a lot, mostly on was observed lying in bed and R4's incontinence product was urated with dark yellow brown was sagging down from the a White folded sheet, at inches by eight inches, R4 had lain, had a dark yellow led of urine. The incontinent to the touch indicating R4 had incontinent product for hours. For thighs and groin were rovided incontinence care and	F6	R1 has since discharged the fact All residents requiring bathing a were reviewed to ensure approphathing schedule in place per repreference. Resident care plans as needed. Nursing staff will be educated of Daily Living policy as well as importance of following the residentered care plan specific to to needs. Staff will also be educated bathing schedules and docume bath refusal. This education will May 20th and 21st, 2021. DON or designee will ensure an compliance of following residen care plans as well as auditing of completion of scheduled baths adocumentation of refusal of schedules week x2 weeks, weekly x2 weeks times per month x2 months. Au presented and reviewed at Qual Council, who will recommend of and on-going monitoring/auditin analysis.	ssistance oriate sident updated in Activities he dent ileting ed on intation of occur on different toileting and/or eduled times per as, and 3 dits will be ity nanges	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 677	During an interview registered nurse (Fresidents in the last incontinence produsometimes feces with the bedding would stated she assess was found soaked R4's skin and foun thighs were redder found to be inconting RN-A took the previnto the resident's assistant on how to incontinence care. occurred with the rithis to the nurse mindividual staff. R5's admission MI had a BIMS score cognition and had (stroke), and gene further indicated R (two or more peopitoileting, and R5 with and bladder.	age 5 le incontinence care and notify of on 4/13/21, at 8: 30 a.m. RN-A) stated she found several at three months whose let was full of urine and when RN-A started her the day R4's room smelled of urine and be soaked with urine. RN -A and R4 after NA-A reported R4 with urine. RN-A assessed d R4's coccyx, groin, and led. When a resident was nent from the previous shift, vious shift's nursing assistant froom, and coached the nursing of appropriately provide. RN-A stated this situation light shift and RN-A reported anager to address with the DS dated 3/2/21, indicated R5 of 15, which indicated intact diagnoses of cerebral infarction ralized weakness. R5's MDS 5 needed extensive assistance le) with all ADLs including as always incontinent of bowel	F 67	77				
	activities of daily living grooming, oral care	ving which included bathing, es, transferring, mobility, vision, . R5's care plan indicated he						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C		
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For a state of the	dated 1/21/20, through dated 1/21/20, through dated to be continent assistance occurrence of the continent assistance occurrent of the continent assistance occurrent of the continent of the con	ndder Monitoring Worksheet ugh 1/23/20, indicated R5 was t for 18 hours when toileting d or when R5 was offered	F 6	77			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER	WHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	
F 677	SHOWERING AN R1's MDS dated Brief Inventory of I 15 indicating intac cancer, septicemia malnutrition. R1's extensive assistan ADLs. R1's Care Area As 11/9/20, indicated that included assis R1's bathing recor indicated R1 recei assistance of one. R1's bathing recor indicated R1 recei assistance of one.	d should be addressed by the rough staff re-education. D BATHING 11/9/20, indicated R1 had a Mental Status (BIMS) score of t cognition and diagnoses of a (systemic infection), and MDS indicated R1 needed nee (two or more people) with all essessments (CAA) dated R1 had care planning for ADLs stance with bathing. Indicated 11/5/20, at 9:27 a.m. wed a partial bed bath with and dated 12/25/20, at 10:44 p.m. wed a complete bed bath with	F 677	,		
	p.m. R1 stated she and no showers defacility. R1 stated sout, which happens she could shower. nursing assistant the night, "but he almoshower." R1 explaymented her to star with assistance of	e only received three bed baths uring her two month stay at the that once her feeding tube was led soon after her admission, R1 stated an unidentified male tried giver her a shower one lost lost control of me in the lined the nursing assistant and up and she could not stand just one person, so the nursing loack to bed and gave her a bed				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245300	B. WING _			C 04/14/2021	
	/HITE BEAR LAKE		1900 WEBBER S	TREET	1 04/14/2021	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH C	ORRECTIVE ACTION SHOULD	BE COMPLÉTION	
During an interview the director of nursi	on 4/14/2021, at 4:27 p.m. ng (DON) verified R1 received	F 67	77			
refusing a bath. The residents to receive baths in between.	e DON stated she expected weekly showers with sponge					
(ADL) policy dated a to provide residents services appropriate ability to carry out A indicated residents ADLs independently necessary to maintal elimination needs. Treatment/Svcs to least to provide the control of	April 2021, indicated staff were with care, treatment, and e to maintain or improve their DLs. The ADL policy further who are not able to carry out y would receive assistance ain personal hygiene and meet	F 68	36		5/28/21	
§483.25(b) Skin Into §483.25(b)(1) Press Based on the compresident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that to (ii) A resident with professional standar promote healing, promote healing, promote healing, promote REQUIREMENTS.	egrity sure ulcers. brehensive assessment of a must ensure that- es care, consistent with ands of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives and services, consistent andards of practice, to event infection and prevent veloping. NT is not met as evidenced		The policy	Prevention and Treati	ment of	
	Continued From particles of the director of nursitive baths during he 12/28/20, and there refusing a bath. The residents to receive baths in between. Review of the facilities (ADL) policy dated to provide residents services appropriate ability to carry out A indicated residents ADLs independently necessary to maintal elimination needs. Treatment/Svcs to CFR(s): 483.25(b)(1) President, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that the first control of the professional standary the professio	PROVIDER OR SUPPLIER TY CARE CENTER - WHITE BEAR LAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 During an interview on 4/14/2021, at 4:27 p.m. the director of nursing (DON) verified R1 received two baths during her stay from 11/2/20, through 12/28/20, and there was no documentation of R1 refusing a bath. The DON stated she expected residents to receive weekly showers with sponge baths in between. Review of the facility's Activities of Daily Living (ADL) policy dated April 2021, indicated staff were to provide residents with care, treatment, and services appropriate to maintain or improve their ability to carry out ADLs. The ADL policy further indicated residents who are not able to carry out ADLs independently would receive assistance necessary to maintain personal hygiene and meet elimination needs. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	PROVIDER OR SUPPLIER TY CARE CENTER - WHITE BEAR LAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 During an interview on 4/14/2021, at 4:27 p.m. the director of nursing (DON) verified R1 received two baths during her stay from 11/2/20, through 12/28/20, and there was no documentation of R1 refusing a bath. 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This REQUIREMENT is not met as evidenced by:	TOTALE CONTROLLER 245300 ROVIDER OR SUPPLIER TY CARE CENTER - WHITE BEAR LAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 During an interview on 4/14/2021, at 4:27 p.m. the director of nursing (DON) verified R1 received two baths during her stay from 11/2/20, through 12/28/20, and there was no documentation of R1 refusing a bath. The DON stated she expected residents to receive weekly showers with sponge baths in between. Review of the facility's Activities of Daily Living (ADL) policy dated April 2021, indicated staff were to provide residents with care, treatment, and services appropriate to maintain or improve their ability to carry out ADLs. The ADL policy further indicated residents who are not able to carry out ADLs independently would receive assistance necessary to maintain personal hygiene and meet elimination needs. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
			7. BOILDIN			С
		245300	B. WING _		1	14/2021
NAME OF F	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP COD	•	1-1/2021
				1900 WEBBER STREET		
CERENIT	TY CARE CENTER -	WHITE BEAR LAKE		WHITE BEAR LAKE, MN 55110		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE 'ROPRIATE	COMPLETION DATE
F 686	Continued From p	page 9	F 68	6		
	review, the facility	failed to follow care planned		Skin Breakdown was reviewe	ed and	
		eal current pressure ulcers (PU),		remains appropriate.		
		pressure ulcers from forming on		R7 has since expired.		
		R7 and R8) reviewed for		R8 had a new Skin Risk w/Bra	den	
	pressure ulcers.	,		completed and his care plan, t	reatment	
				orders, and care sheet were u		
	Findings include:			reflect changes. The Wound R		
				re-assessed wound and as of	5/12/21,	
		sure Injury Advisory Panel		wound closed.		
		njury wound descriptions as		All residents with pressure wor		
	follows:			have a new wound care asses		
	Otawa O. Dawtial th	internal land of altip with		Skin Risk w/Braden completed		
		ickness loss of skin with Γhe wound bed is viable, pink or		and treatment orders updated appropriate based on skin risk		
		ay also present as an intact or		assessments.	and wound	
		led blister. Adipose (fat) is not		Nursing staff will be educated	on the	
		r tissues are not visible.		policy Prevention and Treatm		
		e, slough and eschar are not		Breakdown , use of care she		
		uries commonly result from		plans to determine appropriate		
		nate and shear in the skin over		repositioning and treatment ne		
	the pelvis and she	ear in the heel.		daily skin checks with cares ar skin checks with bathing. NAR		
	Stage 3: Full-thick	ness loss of skin, in which		asked to sign and turn in their		
	adipose (fat) is vis	sible in the ulcer and granulation		at the end of their shift to show	1	
		e (rolled wound edges) are		acknowledgement of resident	•	
		nd/or eschar may be visible.		This education will occur May	20th and	
		e damage varies by anatomical		21st, 2021.		
		significant adiposity can		DON or designee will ensure a		
		unds. Undermining and		compliance. Audits of NAR sig		
		cur. Fascia, muscle, tendon,		sheets and repositioning of res	•	
		e and/or bone are not exposed.		their care plan will be complete		
		r obscures the extent of tissue stageable Pressure Injury.		per week x2 weeks, weekly x2 and 3 times per month x2 mor		
	1055 1115 15 811 0115	siageanie Fressule Ilijury.		will be presented and reviewed		
	Stage 4: Full-thick	ness skin and tissue loss with		Council, who will recommend		
		y palpable fascia, muscle,		and on-going monitoring/auditi		
		cartilage or bone in the ulcer.		analysis.	ing dittol	
		char may be visible. Epibole,		2.10.70.0.		
		or tunneling often occur. Depth				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245300	B. WING _		04	C / 14/2021	
	PROVIDER OR SUPPLIER	VHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110	CODE	1-112021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	varies by anatomical Deep Tissue Press skin with localized a non-blanchable deed discoloration or epirevealing a dark work R8's admission Mir 6/3/20, indicated R8 had diagnoses of Prisk for pressure ule MDS indicated R8 until his quarterly Mindicated R8 had deed assistance (two or transfers, toileting, CAA indicated R8 repericare, managing indicated R8 was to upon request with crounds. The pressures at risk for pressure to provide assistance of two shours, providing incipressure reducing chair, using pressure services.	al location. ure Injury; Intact or non-intact	F 68				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245300	B. WING				C 1 4/2021	
	PROVIDER OR SUPPLIER	/HITE BEAR LAKE		STREET ADDRESS, CITY, STATE, 1900 WEBBER STREET WHITE BEAR LAKE, MN 55		<u> </u>	14/2021	
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
F 686	The Nursing Assista indicated R8 should after meals, and at R8's Skin Risk Assidated 12/16/20, ind R8's progress note R8 had two pressurthere was no descrof size. R8's Event Report of developed a new Sthickness loss of skipain to the area on R8's PN dated 3/5/2 PU measuring 2 ce wide in size. R8's wound nurse R8 had an unstage measuring 3 cm lor deep with 100% slot R8's PN dated 3/21 open area on his coby 0.7 cm wide. R8's Skin Risk Assidated 3/23/21, indicated 10.2 cm deep.	ant Worksheet dated 4/9/21, difference to ileting upon arising, night or per his request. Dessment completed by RN-A icated R8 had no PU's. (PN) dated 2/24/21, indicated re ulcers on his coccyx but iption of the PUs or indication dated 2/24/21, indicated R8 tage 2 PU with partial cin layers and included mild his coccyx. 21, indicated R8 had a Stage 2 ntimeters (cm) long by 5 cm PN dated 3/17/21, indicated able PU on his coccyx and by 0.6 cm wide by 0.1 cm	F 6	86				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		COM	E SURVEY PLETED
		245300	B. WING			1	C 14/2021
	PROVIDER OR SUPPLIER	VHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP 1900 WEBBER STREET WHITE BEAR LAKE, MN 5511		1 04	1-1/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD IE APPROPI	BE	(X5) COMPLETION DATE
F 686	R8 was laying in be elevated and the he angle. During intervhad a "sore on my came to the facility not sure if it was get buring an interview registered nurse (R document when rest they are in one post documentation of to buring continuous 8:57 a.m. through 1 wheelchair and eati R8 ate a continentatelevision, and at 10 (NA)-E brought R8 NA-E stated R8 wareturn him to bed. A transferred R8 from placed him on his bechecked nor was he time. During an interview stated sitting up in this bottom "so much was in bed. R8 shis side when he whim to do by himse but he sometime restated he could not stated he was in the morning because the breakfast.	ed on his back with his legs ead of the bed at a 30 degree view at this time, R8 stated he butt" that developed after he R8 stated it hurt and he was	F 6	86			

AND DIAN OF CODDECTION INDENTIFICATION NUMBER.		` ′	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		245300	B. WING		04	C / 14/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1900 WEBBER STREET WHITE BEAR LAKE, MN 5511	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	NA-E stated she tr wheelchair around position should be NAs did not docum residents, stating, turn." NA-E stated was toileted after r NA-E stated a crea area after toileting any open sores. Na toileted two to thre R8 was in the whe almost three hours During continuous 7:28 a.m. through bed, lying on his ba 9:52 a.m.; three ho During an interview NA-D stated the st reposition resident was set." NA-D wa been on his back to NA-D began his sh was last turned at assistants did not of they did not record repositioned or for position. During an observa RN-F changed R8' observed on R8's of 0.5 cm and RN-F to Tegaderm agilnate observed to also h the inferior aspect	ansferred R8 from bed to the 8:15 a.m. and stated R8's changed every two hours but nent when they repositioned "we just know when it's time to to prevent skin breakdown, R8 neals and when he needed it. am was applied to R8's perineal and then a dressing goes over A-E stated she thought R8 only e times a shift. NA-E verified elchair for over two hours, and was not repositioned. observation on 4/14/21, from 10:30 a.m. R8 was observed in ack from 7:28 a.m. through	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245300	B. WING _		04	C / 14/2021
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	Continued From p	age 14	F 68	6		
	RN-F described the pressure ulcer and During an interview NA-C stated nursing the pressure of	e a "diaper rash of a baby." le coccyx wound as a Stage 2 d stated it was "healing nicely." ly on 4/14/21, at 12:10 p.m., lng assistants observe ling care and would report any nurse.				
	RN-A stated when identified, staff wo dietician and wour	w on 4/14/21, at 2:37 p.m., a new wound or PU was uld write an event note and the nd nurse would be notified. The d then evaluate and measure eekly basis.				
	director of nursing on 2/24/21, and no 3/17/21, the PU wastated a preference wound nurse for or documentation. The ducating nurses of the state of t	w on 4/14/21, at 4:27 p.m. the (DON) verified R8's PU started of the very started of very started of the very started of very started of the very started of very started of the very star				
	was at risk for pres incontinent of bow further indicated R	S dated 3/20/21, indicated R7 ssure ulcers and was always el and bladder. R7's MDS to required assistance with bed toileting, and hygiene.				
	inability to participal weakness and Participal episodes of bowel CAA indicated staf	I/6/20, indicated R7 had an ate in self cares related to rkinson' disease with frequent and bladder incontinence. The ff should provide assistance care, and managing				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245300	B. WING _		04	/14/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110		, , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	R7's care plan data risk for impaired sincluded cleansing gluteal fold with we Calmoseptine lotion R7's Event Report dated 4/9/21, indicated as a cleanse with wound care order every other day are position on the same position on the same position on the sea either sleeping or entire two and one of the standar or repositioned every should be laid download the pressure	ed 4/12/21, indicated R7 was at kin integrity and interventions of the open area on her right bound cleanser and on. If or skin integrity pressure sore sated R7 was found to have a right gluteal fold which long by 1 cm wide. Order dated on 4/9/21, indicated sess the right gluteal fold, indicated to change are with a foam dressing. The further indicated to change and as needed. Observation on 4/13/221, from p.m., R7 was observed sitting on in her wheelchair with a lat of the wheelchair and was watching television for the	F 68	6		
	DON stated reside care plan, Braden	n 4/14/21, at 4:33 p.m. the ents should be repositioned per scale, manager and patient recommendation.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
		245300	B. WING _			C 14/2021
	PROVIDER OR SUPPLIER	/HITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110	1 04/	14/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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	(X5) COMPLETION DATE
F 686	The DON further st the Treatment Adm resident had position but it did not indicat was or the time of t stated we have end residents and my exprovide care accord. The facility's Prever Breakdown/Pressure.	ated nurses documented in inistration Record (TAR) if a on changed during the shift, we what the position change the position change. The DON ough staff to reposition the expectations was for staff to ding to the care plan. Intion and Treatment of Skin are Injury policy dated 2018,	F 68	6		
	and if there were all documented in the performed a weekly and when if a new performed in a weekly basis the measure, and exan surrounding skin." I when a pressure in		F 88	0		5/28/21
	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es	tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245300	B. WING			1	C 14/2021
	PROVIDER OR SUPPLIER	WHITE BEAR LAKE		1900	ET ADDRESS, CITY, STATE, ZIP CODE WEBBER STREET FE BEAR LAKE, MN 55110	1 04/	14/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	a minimum, the foll §483.80(a)(1) A system or communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national services for the but are not limited to (i) A system of survices possible communicable diserported; (iii) When and to whom communicable diserported; (iii) Standard and the tobe followed to provide (ii) When and how resident; including (iii) When and how resident; including (iiiiii) Standard and the tobe followed to provide (iii) When and how resident; including (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessmenting to §483.70(e) and following standards; en standards, policies, and program, which must include, oc: eillance designed to identify able diseases or ey can spread to other ty; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a put not limited to: uration of the isolation, exinfectious agent or organism that the isolation should be the sible for the resident under the context of the side of	F8	80			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	COM	E SURVEY IPLETED
		245300	B. WING		l l	C 14/2021
	PROVIDER OR SUPPLIE	R WHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP COD 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 880	\$483.80(a)(4) A sidentified under the corrective actions \$483.80(e) Linem Personnel must he transport linens sinfection. \$483.80(f) Annual The facility will confect the property will confect the property of the spread of the	page 18 System for recording incidents the facility's IPCP and the staken by the facility. Solutions. Solution incidents the spread of the	ı		and were riate. on the Hand quipment then to oriate glove reusable tely oractices use and of on 4/14 oloyed at	
	required extensive with activities of continuous bathing, toileting, During continuous 9:34 a.m. through room without performance of the continuous production of the continuous production of the continuous performance of the continuous performan	laily living (ADL) including personal hygiene, and transfers. s observation on 4/14/21, at 10:35 a.m. NA-D entered R8's forming hand hygiene and a partial bed bath and donning a		compliance. Audits of hand hy use, and cleaning of resident of equipment will be completed 3 week x2 weeks, weekly x2 we times per month x2 months. A presented and reviewed at Qu Council, who will recommend and on-going monitoring/auditi	rgiene, glove care 3 times per eks, and 3 audits will be ality changes	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245300	B. WING				C 14/2021
	PROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 900 WEBBER STREET VHITE BEAR LAKE, MN 55110	<u> </u>	14/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	shirt, pants, and so brief in place. NA-D performing hand hy room with NA-C; Naupon entering the rehand hygiene. Usin NA-D stood R8 fror donned gloves and R8 was transferred the soiled brief and but did not perform gloves. R8 remaine RN-A arrived to asswithout performing gloves to assist NA while NA-D donned perineal care. NA-D perform hand hygien NA-D positioned a NA-C, and NA-D piassisted him back ther gloves and exiting performing hand hy the sink to assist R rinsing R8's denture room and did not pexiting the room. During an interview NA-D stated hand hy hynot sure.	cks but leaving soiled adult exited R8's room without rgiene. NA-D returned to R8's A-C performed hand hygiene oom but NA-D did not perform g a transfer belt, NA-C and a wheelchair; NA-D then removed R8's soiled brief and to the toilet. NA-D disposed of his gloves at the same time hand hygiene after doffing the deseated on the toilet until sist. JRN-A entered R8's room hand hygiene and donned -C with getting R8 to his feet gloves and performed doffed the gloves, did not ene, and donned new gloves. Clean brief on R8. RN-A, woted R8 from the toilet and to his wheelchair. RN-A doffed ed the room without rgiene. NA-D wheeled R8 to 8 with oral care, washing and es. NA-D returned R8 to the erform hand hygiene upon	F 8	880	analysis. See attached DPOC documents.		
	had diagnoses of d	S dated 3/9/21, indicated R4 iabetes and a gastronomy directly inserted into the e abdomen).					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245300	B. WING _			/14/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	Continued From pa	age 20 OS dated 3/23/21, indicated R3	F 88	0		
	had diagnoses of p	oneumonia, chronic kidney and sepsis (a systemic				
		MDS dated 4/12/21, indicated s of chronic lung disease and ease.				
	8:20 a.m. through (NA)-B obtained w different residents equipment (blood pand thermometer)	observations on 4/14/21, from 8:45 a.m. nursing assistant eights and vital signs on three using the same set of vital sign pressure cuff, pulse oximeter, without cleaning the equipment				
	hygiene: * NA-B entered R4 hand hygiene and the shower/tub roo wheeled R4 into th	and without performing hand 's room without performing wheeled R4 from his room to m to obtain R4's weight. NA-B e hallway where the vital sign				
	pressure, pulse, or temperature. NA-E NA-B did not clear and did not perforr					
	hand hygiene and room to obtain R3' into the hallway wh	d R3's room without performing wheeled R3 to the shower/tub s weight. NA-B wheeled R3 nere the same vital sign sated that had been used with				
	R4. NA-B took R3' pressure, pulse, ox temperature. NA-E	s vital signs including blood kygen saturation, and wheeled R3 back to her room. the equpment after use on R3				
	and did not perforr *NA-B entered R12					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245300	B. WING		04	C / 14/2021
	PROVIDER OR SUPPLIER	VHITE BEAR LAKE		STREET ADDRESS, CITY, STATE, ZIP 1900 WEBBER STREET WHITE BEAR LAKE, MN 5511	CODE	11412021
(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 CO ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	room to obtain R12 into the hallway whe equipment was local R4 and R3. NA-B to blood pressure, pultemperature. NA-B after use on R12 and hygiene. During an interview stated he did not cleach resident and fiperform hand hygiewhen obtaining vital not think he had to not perform person care on the resident completed education system) During an interview director of nursing was for hand hygiehands are visibly so care, removal of perform hand hygiene was and water or with his stated staff would water or with his tated staff would work to requipment should be wipe in between ear the facility's Hand indicated staff should before and after an hand hygiene policy.	ere the same vital sign ated that had been used with book R12's vital signs including se, oxygen saturation, and did not clean the equipment and did not perform hand on 4/14/21, at 8:47 a.m. NA-B ean the equipment in between further confirmed he did not ene between each resident al signs. NA- B stated he did wash his hands since he did all cares such as incontinence at. NA-B further stated he on on Relias (electronic on hand hygiene. If on 4/14/21, at 4:33 p.m. the (DON) stated her expectation ne to be performed when biled, before and after patient ersonal protective equipment, at was fed. The DON stated expected to be done with soap and sanitizer. The DON further wear gloves when personal se were completed. The DON xpectation was medical be cleaned with a sanitizing		80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245300	B. WING			C / 14/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	contact with a resi taking vitals or after The facility's Residuated 6/17, indicated reusable equipme	age 22 dent's intact skin, such as when er assisting with lifting. dent Care Equipment policy, ted staff would disinfect int between residents using an tection agency (EPA) approved	F8	80		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 4, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: 43CF11

Dear Administrator:

The above facility was surveyed on April 12, 2021 through April 14, 2021 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900

Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Flig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :	COMPLETED
		00923	B. WING		C 04/14/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY,	STATE, ZIP CODE	
CEDENIT	TY CARE CENTER - W	1900 W	EBBER STRE		
CERENI	IT CARE CENTER - W	WHITE	BEAR LAKE, I	MN 55110	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEI	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.			
	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 alle number indicated below. It is several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was			
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.			
Minnosota D	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction ye	rs: 14/14/21, a complaint survey rour facility by surveyors from artment of Health (MDH). You IOT in compliance with the MI ease indicate in your electron ou have reviewed these order e when they will be completed	N ic rs		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/14/21

STATE FORM 6899 43CF11 If continuation sheet 1 of 20

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00923	B. WING			C 14/2021
	PROVIDER OR SUPPLIER	VHITE BEAR I AK	DDRESS, CITY, S BBER STREE BEAR LAKE, M	т		
(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 ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	The following comp SUBSTANTIATED: * H5300050C (MNC orders issued at 08 * H5300051C (MNC orders issued at 08 The following comp UNSUBSTANTIATE * H5300052C (MNC order was issued at 08 Minnesota Department the State Licensing Federal software. The state Licensing Federal software. The state state of the findings in the far leading. The state state of the correction order the findings which a statute after the state as evidence by. For findings are the Sugand Time Period for You have agreed to receipt of State lice the Minnesota Dep Informational Bullet	plaints were found to be 20071656) with licensing 40, 0900, and 1805. 20068525) with licensing 40, 0900, and 1805. 20168525) with licensing 40, 0900, and 1805. 20168525) with licensing 201781), a related licensing 201781), a related licensing 201781, a r				
	Tag." The state stalisted in the "Summ column and replace the correction orde the findings which a statute after the status as evidence by." For findings are the Sugand Time Period for You have agreed to receipt of State lice the Minnesota Dep Informational Bullet http://www.health.sobul.htm. The State delineated on the a	atute/rule out of compliance is lary Statement of Deficiencies' es the "To Comply" portion of r. This column also includes are in violation of the state atement, "This Rule is not met ollowing the surveyor 's ggested Method of Correction r Correction. In participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/infectionsing orders are ttached Minnesota				
	Department of Hea you electronically. is necessary for Sta	ttached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please 'RRECTED" in the box				

Minnesota Department of Health

STATE FORM 6899 43CF11 If continuation sheet 2 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
				С		
		00923	B. WING		04/1	4/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CERENIT	TY CARE CENTER - V	/HITF BFAR I AK	BBER STREE EAR LAKE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 840	0 MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin		2 840			5/28/21
	Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:					
	odors. A bathing pl resident's plan of ca condition requires t must be given a co other day and more incontinent resident every two hours, ar	and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every e often as indicated. An it must be checked at least and must receive perineal care node of incontinence.				
	Notwithstanding Mi 4658.0520, an inco checked according written in the reside attending physician	Incontinent residents. Incontinent residents. Innesota Rules, part Intinent resident must be Ito a specific time interval Intitient's care plan. The resident's Intitient authorize in writing any Itwo hours unless the resident,				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00923	B. WING			4/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CERENI	TY CARE CENTER - V	VHITE BEAR I AK	BBER STREE EAR LAKE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	if competent, or a fappointed conserva agent of a resident in writing to waive put determining this into documented in the Clean linens or clot promptly each time Perineal care including the perineal area. To keep the bed dry comfort. Special askin to prevent irritatypes of protectors completely covered contact with the resident in the perineal care.	amily member or legally ator, guardian, or health care who is not competent, agrees ohysician involvement in erval, and this waiver is resident's care plan.] thing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be d, and not come in direct sident. Soiled linen and emoved immediately from	2 840			
	by: Based on observat review the facility fa care to 2 of 3 resid provide weekly battl reviewed for assist living (ADLs) provid Findings include: INCONTINENCE C R4's admission Mir 3/9/21, indicated R Status (BIMS) of 8, impaired cognition	ent is not met as evidenced ion, interview, and document ailed to to provide incontinence ents (R4 and R5) and failed to hs for 1 of 3 residents (R1) ance with activities of daily ded to dependent residents. CARE nimum Data Set (MDS) dated 4 had a Brief Interview Mental which indicated moderately and diagnoses of dementia MDS also indicated R4 was		Corrected		

Minnesota Department of Health

STATE FORM 6899 43CF11 If continuation sheet 4 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			TE SURVEY MPLETED	
						С	
		00923	B. WING		04/	14/2021	
NAME OF PROVIDER OR SU	PPLIER			STATE, ZIP CODE			
CERENITY CARE CENT	ER - W	HITE BEAR I AK	BBER STREI EAR LAKE, I				
PREFIX (EACH DEF	ICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
During an obthe doorway came from the went into R4 training (NAT was strong, athe night shift when he storobserved to colored urine weight of the approximate underneath weight of the approximate underneath wet area that product was likely worn the R4's buttockereddened. Not dressed R4 we buring an interest stated the night soiled inconting staff soiled inconting staff soiled inconting the incontinence when she four coming from appeared to resident's skimmediately the nurse.	inent of stance servation R4's e room of R4's e saturation e saturation e saturation e room of R4's e room of R	of bladder and bowel and of one person with toileting. on on 4/12/21, at 8:45 a.m. in a room, a strong urine smell in. Nursing assistant (NA)-A with nursing assistant in A-A stated the smell of urine "this happens a lot, mostly on was observed lying in bed and R4's incontinence product was urated with dark yellow brown has sagging down from the A white folded sheet, inches by eight inches, R4 had lain, had a dark yellow ed of urine. The incontinent the touch indicating R4 had incontinent product for hours. It thighs and groin were ovided incontinence care and					

Minnesota Department of Health

STATE FORM 6899 43CF11 If continuation sheet 5 of 20

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` ′	P) MULTIPLE CONSTRUCTION BUILDING:		(X3) DATE SURVEY COMPLETED	
		00923		B. WING		I	C 14/2021	
CERENITY CARE CENTER - WHITE BEAR LAK 1900 WEB			DDRESS, CITY, STATE, ZIP CODE BBER STREET BEAR LAKE, MN 55110					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 840	residents in the last incontinence produsometimes feces with shift. RN-A stated Fithe bedding would listated she assessed was found soaked R4's skin and found thighs were redden found to be incontinented the resident's reassistant on how to incontinence care.	ige 5 It three months whose It was full of urine and Ithen RN-A started he Ither RA's room smelled of Ithe soaked with urine Ither RA's coccyx, groin, Ither RA's coccyx, groi	nd er the day furine and e. RN -A orted R4 essed and ewas us shift, ssistant ne nursing le ation eported	2 840				
	had a BIMS score of cognition and had of (stroke), and gener further indicated R5 (two or more people toileting, and R5 was and bladder.	PS dated 3/2/21, indicated of 15, which indicated diagnoses of cerebra alized weakness. R5 needed extensive a e) with all ADLs includes always incontinent	d intact Il infarction I's MDS assistance Iding t of bowel					
	extensive assistant activities of daily liv grooming, oral care	ed 3/5/21, indicated Force (two or more peoping which included bes, transferring, mobings; care plan indicated Force	ole) with athing, ility, vision,					
	dated 1/21/20, through	ndder Monitoring Wo ugh 1/23/20, indicate t for 18 hours when t d or when R5 was of nours.	ed R5 was toileting					

Minnesota Department of Health

STATE FORM 6899 43CF11 If continuation sheet 6 of 20

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00923		B. WING			C 14/2021
	PROVIDER OR SUPPLIER	WHITE BEAR LAK	1900 WEE	DRESS, CITY, S BBER STREE EAR LAKE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 840	stated he needed he transferring to the treat call light and waited receive assistance explained he could dry if he did not have assistance. During an interview licensed practical news sometimes have to we caring for other results. R5 might have to we caring for other results as incontinent two staff for cares as longer to get two stationary two stationary to get two stationary two stationary transfer to get two	ge 6 on 4/12/21, at 9:00 a elp getting out of bedoilet. R5 stated he us I up to two hours at r from the nursing statkeep his incontinent ve to wait for two hours on 4/12/21, at 11:30 urse (LPN)-A stated rd at nights and weel ait longer because sidents. LPN-A stated and required assistand transfers, it would aff to help assist the 4/13/2021, at 2:00 p. N)-E stated R5 was . RN-E stated R5 was . RN-E stated she had om R5 about waiting provide toileting assist on 4/14/21, at 4:33 provide toileting assist toileted or changed a DN also stated she eff not providing care should be addresse ough staff re-education	d and sed his hight to ff. R5 product irs to get a.m. staffing kends so taff were because ance of d take R5 to the o.m. ad not ground too long stance. p.m. the nence to the ation was as soon expected to a d by the	2 840			
	SHOWERING AND	BATHING 1/9/20, indicated R1	had a				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00923	B. WING		04/1	4/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CERENI	TY CARE CENTER - V	VHITE BEAR I AK	BBER STREE			
(V4) ID	SLIMMADV STA	ATEMENT OF DEFICIENCIES	EAR LAKE, N	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 840	Continued From pa	nge 7	2 840			
	Brief Inventory of Mental Status (BIMS) score of 15 indicating intact cognition and diagnoses of cancer, septicemia (systemic infection), and malnutrition. R1's MDS indicated R1 needed extensive assistance (two or more people) with all ADLs.					
	R1's Care Area Assessments (CAA) dated 11/9/20, indicated R1 had care planning for ADLs that included assistance with bathing.					
	R1's bathing record dated 11/5/20, at 9:27 a.m. indicated R1 received a partial bed bath with assistance of one.					
		d dated 12/25/20, at 10:44 p.m. red a complete bed bath with				
	During a phone interview on 4/13/2021, at 1:06 p.m. R1 stated she only received three bed baths and no showers during her two month stay at the facility. R1 stated that once her feeding tube was out, which happened soon after her admission, she could shower. R1 stated an unidentified male nursing assistant tried giver her a shower one night, "but he almost lost control of me in the shower." R1 explained the nursing assistant wanted her to stand up and she could not stand with assistance of just one person, so the nursing assistant put her back to bed and gave her a bed bath.					
	the director of nurs two baths during he 12/28/20, and there refusing a bath. The	on 4/14/2021, at 4:27 p.m. ing (DON) verified R1 received er stay from 11/2/20, through e was no documentation of R1 e DON stated she expected e weekly showers with sponge				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00923	B. WING		1	C 1 4/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CERENIT	TY CARE CENTER - W	VHITE BEAR I AK	BBER STREE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	EAR LAKE, N	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 840	Continued From pa	ge 8	2 840			
	(ADL) policy dated at to provide residents services appropriate ability to carry out A indicated residents ADLs independently necessary to maintage elimination needs. SUGGESTED MET The director of nurse could educate respresidents dependent residents' compreh DON or designee of dependent resident hygiene needs are	ty's Activities of Daily Living April 2021, indicated staff were swith care, treatment, and e to maintain or improve their DLs. The ADL policy further who are not able to carry out y would receive assistance ain personal hygiene and meet THOD OF CORRECTION: sing (DON) and/or designee onsible staff to provide care to not on facility staff, based on ensively assessed needs. The could conduct audits of cares to ensure their persona met consistently. R CORRECTION: Twenty-one				
2 900	, ,	5 Subp. 3 Rehab - Pressure	2 900			5/28/21
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	B. a resident w	ho has pressure sores				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00923	B. WING		04/1	2 4/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	-	
CERENI	TY CARE CENTER - V	VHITE BEAR I AK	BBER STRE BEAR LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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)	ILD BE	(X5) COMPLETE DATE
2 900	Continued From pareceives necessary promote healing, promote healing health for the same prevent new promote and prevent ulcers. Findings include: The National Press defined pressure infollows: Stage 2: Partial-thic exposed dermis. The red, moist, and may ruptured serum-filled visible and deeper for Granulation tissue, present. These injuications and sheal stage 3: Full-thick nadipose (fat) is visible tissue and epibole (present. Slough and present. Slough and present. Slough and present stage and promote the present shough and promote the present should be present. Slough and present should be present. Slough and present should be present.	ge 9 y treatment and services to revent infection, and prevent veloping. ent is not met as evidenced on, interview, and document ailed to follow care planned al current pressure ulcers (PU) ressure ulcers from forming or and R8) reviewed for ure Injury Advisory Panel jury wound descriptions as exhess loss of skin with the wound bed is viable, pink or also present as an intact or ad blister. Adipose (fat) is not tissues are not visible. slough and eschar are not ries commonly result from the and shear in the skin over	2 900			
	location; areas of sidevelop deep wountunneling may occuligament, cartilage	ignificant adiposity can ids. Undermining and ir. Fascia, muscle, tendon, and/or bone are not exposed. obscures the extent of tissue				

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STATEMENT OF DEI AND PLAN OF CORF		(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00923		B. WING			C 14/2021
NAME OF PROVIDE		VHITE BEAR LAK	1900 WEE	DRESS, CITY, S BBER STREE EAR LAKE, N			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
loss the Stage exposite tendor Slough undern varies Deep skin we non-ble discolor reveal R8's a 6/3/20 had dirisk for MDS is until he indicated transfer CAA in perical indicated upon reveal to the skin were to mobility.	4: Full-thickred or directly and ligament, on and/or eschaning and/or by anatomic Tissue Pressith localized anchable depration or eping a dark would describe the described the describe	ageable Pressure Injuness skin and tissue in palpable fascia, mustartilage or bone in the par may be visible. En tunneling often occi	loss with scle, he ulcer. pibole, ur. Depth hon-intact ole ation ed blister. S) dated ne 2020, and was at arterly ure ulcer when it ulcer. ed e mobility, continence he with and he night ed R8 cated staff with bed urs. R8 was at	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00923		B. WING			C 14/2021
	OVIDER OR SUPPLIER	/HITE BEAR LAK	1900 WEE	DRESS, CITY, S BBER STREE EAR LAKE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F F F F F F F F F F F F F F F F F F F	oressure reducing of chair, using pressure using a moisture barea. The Nursing Assistandicated R8 should after meals, and at R8's Skin Risk Assedated 12/16/20, ind R8's progress note R8 had two pressur here was no description of size. R8's Event Report of developed a new Signification of the area on R8's PN dated 3/5/2 PU measuring 2 cellidering a comparation of size. R8's wound nurse FR8 had an unstage measuring 3 cm lored deep with 100% slow R8's PN dated 3/21 open area on his copy 0.7 cm wide. R8's Skin Risk Assedated 3/23/21, indicated 3/23/21, indicated size and six	continence care, using cushions in the wheel re reduction when in arrier product to the part Worksheet dated a receive toileting upinight or per his required icated R8 had no PU (PN) dated 2/24/21, re ulcers on his cocciption of the PUs or included a pure and included his coccyx. 21, indicated R8 had no PU (PN) dated 3/17/21, included the PU on his cocciption of the PUs or included his coccyx.	elchair or bed, and berineal 4/9/21, on arising, est. by RN-A J's. indicated by but ndication ated R8 alled mild a Stage 2 by 5 cm dicated yx o 0.1 cm and an cm long by RN-A ured 3.0	2 900			

6899

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00923	B. WING		l l	C 14/2021
	PROVIDER OR SUPPLIER	HITE BEAR LAK 1900 WEE	DRESS, CITY, S BBER STREE EAR LAKE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	R8's wound nurse R8's PU measured 0.2 cm deep. During an observat R8 was laying in be elevated and the he angle. During intervhad a "sore on my came to the facility not sure if it was ge. During an interview registered nurse (R document when resthey are in one postocumentation of tw.) During continuous 8:57 a.m. through 1 wheelchair and eatir R8 ate a continentatelevision, and at 10 (NA)-E brought R8 NA-E stated R8 wareturn him to bed. A transferred R8 from placed him on his bechecked nor was he time. During an interview stated sitting up in this bottom "so much was in bed. R8 shis side when he whim to do by himselbut he sometime room to be sure to the sometime room to be sure to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed. R8 shis side when he whim to do by himselbut he sometime room to the was in bed.	PN dated 4/1/21, indicated the 2.5 cm long by 0.5 cm wide by ion on 4/12/21, at 1:58 p.m., d on his back with his legs ead of the bed at a 30 degree riew at this time, R8 stated he butt" that developed after he R8 stated it hurt and he was	2 900			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		00923	B. WING		04/1	4/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CERENI	TY CARE CENTER - V	VHITE BEAR I AK	BBER STREE EAR LAKE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 900	Continued From pa	nge 13	2 900			
	morning because that was when they brought him breakfast.					
	NA-E stated she tra wheelchair around position should be on NAs did not docum residents, stating, " turn." NA-E stated it was toileted after in NA-E stated a creal area after toileting a any open sores. NA toileted two to three R8 was in the wheel almost three hours. During continuous of 7:28 a.m. through of bed, lying on his bated, lying on his bated, lying on his bated, lying an interview. NA-D stated the state reposition residents was set." NA-D was been on his back been on his back been on his back been on his shad assistants did not determined the state of the stat	ansferred R8 from bed to the 8:15 a.m. and stated R8's changed every two hours but tent when they repositioned we just know when it's time to to prevent skin breakdown, R8 neals and when he needed it. Im was applied to R8's perineal and then a dressing goes over A-E stated she thought R8 only the times a shift. NA-E verified elchair for over two hours, and was not repositioned. Observation on 4/14/21, from 10:30 a.m. R8 was observed in ack from 7:28 a.m. through urs. You and a 10:30 a.m., and and of care was to severy two hours but "nothing is unsure how long R8 had to the was on his back when ift and NA-D speculated R8 7:00 a.m. NA-D stated nursing document in the computer and when a resident was how long they stayed in one				
	RN-F changed R8's observed on R8's c 0.5 cm and RN-F u	tion on 4/14/21, at 12:20 p.m. s PU dressing and a PU was coccyx about 1.5 cm x 0.5 cm x ised a Q-tip to pack the into the wound. R8 was				

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00923	B. WING			C 14/2021
	PROVIDER OR SUPPLIER TY CARE CENTER - W	VHITE BEAR I AK	ADDRESS, CITY, S VEBBER STREE BEAR LAKE, N	ET	·	
(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	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	observed to also hat the inferior aspect of described the excordollar and was like RN-F described the pressure ulcer and During an interview NA-C stated nursing resident's skin during skin issues to the normal describing an interview RN-A stated when a identified, staff wour dietician and wound wound nurse would the wound on a week director of nursing (on 2/24/21, and not 3/17/21, the PU was stated a preference wound nurse for condocumentation. The educating nurses of still worried wounds and correctly meas R7's quarterly MDS was at risk for presincontinent of bower further indicated R7 mobility, transfers, R7's CAA dated 11/1 inability to participal	ave a dark pink excoriation of his right buttock. RN-F riation as the size of a silver a "diaper rash of a baby." a coccyx wound as a Stage 2 stated it was "healing nicely on 4/14/21, at 12:10 p.m., g assistants observeng care and would report an urse. I on 4/14/21, at 2:37 p.m., a new wound or PU was ld write an event note and the nurse would be notified. The then evaluate and measure ekly basis. I on 4/14/21, at 4:27 p.m. the (DON) verified R8's PU started with the next assessments unstageable. The DON for measurement by the nsistency with weekly a DON stated they tried in how to measure PU but the were not being consistently were not being consistently.	e ed t			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00923		B. WING			C 14/2021
	PROVIDER OR SUPPLIER	/HITE BEAR I AK	900 WEB	DRESS, CITY, S BBER STREE EAR LAKE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	with toileting, perical incontinence product R7's care plan date risk for impaired skincluded cleansing gluteal fold with wor Calmoseptine lotion R7's Event Report of dated 4/9/21, indicastage 2 PU on the measured 1.5 cm lot R7's wound care or to observe and associeanse with wound ointment, and cover wound care order for every other day and During continuous of 11:30 a.m. to 2:00 pin the same position cushion on the seat either sleeping or wentire two and one During interview on stated the standard or repositioned every should be laid down load the pressure we R7 was still up in he interview.	should provide assistanter, and managing cts. d 4/12/21, indicated R7 in integrity and intervent the open area on her rigund cleanser and in. for skin integrity pressurated R7 was found to haright gluteal fold which ong by 1 cm wide. der dated on 4/9/21, indicated to change in the right gluteal fold it cleaner, apply Calmost with a foam dressing. For with a foam dressing with a foam dressing. In the wheelchair with the of the wheelchair with the of the wheelchair and watching television for the half hours. 4/13/21, at 2:00 p.m. R was for residents to be ry two hours. RN-B state in bed after brunch to cound site on her backsier wheelchair during this er wheelchair during this	was at tions ght e sore ve a licated l, eptine The ge , from sitting a was e N-B turned ed R7 off ide.	2 900			
		4/14/21, at 4:33 p.m. thats should be repositioned acale, manager					

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00000			044	
		00923	l.		04/1	4/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S BBER STREE	STATE, ZIP CODE		
CERENI	TY CARE CENTER - V	VHITE BEAR I AK	EAR LAKE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
2 900	recommendation, a The DON further st the Treatment Adm resident had positic but it did not indicat was or the time of t stated we have enc residents and my e provide care accord The facility's Preve Breakdown/Pressu indicated: 1) skin w and if there were al documented in the performed a weekly and when if a new was documented ir a weekly basis the measure, and exan surrounding skin." when a pressure in orders/protocols for initiated. SUGGESTED MET The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. Ti designee, could co delivery of care; to services are impler pressure ulcer deve	and patient recommendation. ated nurses documented in inistration Record (TAR) if a on changed during the shift, the what the position change he position change. The DON bough staff to reposition the expectations was for staff to ding to the care plan. Intion and Treatment of Skin re Injury policy dated 2018, as observed daily with cares conormal findings, it was to be record; 2) licensed nurses y skin audit on all residents pressure injury occurred, it in the medical record; and 3) on license nurse would "stage, nine the wound bed and in addition, the policy indicated jury occurred, standing or skin impairment were THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure the necessary to prevent pressure ulcers do to promote healing of the director of nursing or noduct random audits of the ensure appropriate care and nented; to reduce the risk for	2 900			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00923		B. WING		04/1	2 4/2021
NAME OF I	PROVIDER OR SUPPLIER		STDEET AD	DDESS CITY S	STATE, ZIP CODE	1 04/1	7/2021
				BBER STREE			
CERENI	TY CARE CENTER - W	/HITF BFAR I AK		EAR LAKE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 17		21805			
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients ac.Bill of Rights	&	21805			5/28/21
	residents have the courtesy and respe	us treatment. Patients right to be treated with ct for their individuality rsons providing servic	ı ⁄ by				
	by: Based on observati review the facility fa	ent is not met as evident, interview, and docuiled to call residents but of 3 (R1) residents vilignity.	ument by their		Corrected		
	Findings include:						
	11/9/20, indicated F Mental Status (BIM- intact cognition with	imum Data Set (MDS R1 had a Brief Interview S) score of 15, indicat a a diagnosis of cance needed extensive assi daily living (ADLs).	w for ing r. R1's				
	had a BIMS of 13, v	S dated 3/23/21, indic which indicated intact on neumonia and acute					
	R14 had a BIMS of cognition with diagr fractures (broken be	DS dated 4/12/21, indi 15, which indicated in loses of trauma and m ones). R14's MDS furt assistance with ADLs	tact nultiple ther				
		on 4/13/21, at 1:06 p. stant (NA)-B "always"					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
00923		B. WING			C 04/14/2021				
NAME OF PROVIDER OR SUPPLIER CERENITY CARE CENTER - WHITE BEAR LAK STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION SHOULD BE COR		(X5) COMPLETE DATE			
21805	me "hon" and she of told NA-B not to cal her request and R1 but "nothing change During an observed NA-B was observed During an observed NA-B was observed During an interview stated he called ever man "friend." NA-B permission from the "hon" or "friend" an should not address During an interview director of nursing of residents by their pobtained by social so DON stated some sas a term of endea not like it, they wou them if they were usually the signee could devicate by the interdistresidents dignity is could update policies staff on these chan resident(s) dignity as social signed to the signee could devicate by the interdistresidents dignity is could update policies staff on these chan resident(s) dignity as social signed to the second could update policies staff on these chan resident(s) dignity as social signer could update policies staff on these chan resident(s) dignity as social signer could update policies staff on these chan resident(s) dignity as social signer could update policies staff on these chan resident(s) dignity as social signer could update policies staff on these chan resident(s) dignity as social signer could update policies staff on these chan resident(s) dignity as social signer could update policies staff on these chan resident(s) dignity as social signer could update policies staff on these chan resident(s) dignity as social signer could update policies staff on these channels are sidents.	did not like it. R1 stated she ll her "hon" but NA-B ignored told registered nurse (RN)-D ed." ion on 4/14/21, at 8:30 a.m. d calling R14 "my friend." ion on 4/14/21, at 8:40 a.m. d calling R3 "hon." ion on 4/14/21, at 8:45 a.m. d calling R14 "hon." on 4/14/21, at 8:50 a.m. NA-Bery woman "hon" and every stated he did not ask e residents before calling them d no residents told him he							

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPI	(X3) DATE SURVEY COMPLETED						
CERENITY CARE CENTER - WHITE BEAR LAK 1900 WEBBER STREET WHITE BEAR LAKE, MN 55110 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		00923	B. WING									
WHITE BEAR LAKE, MN 55110 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) WHITE BEAR LAKE, MN 55110 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE												
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE	I CERENITY CARE CENTER - WHITE BEARTAK											
DEFICIENCY)	PRÉFIX (EACH DEFICI	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE COMPLETE								
21805 Continued From page 19 21805	21805 Continued From	ued From page 19	21805									
TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	TIME PERIOD	PERIOD FOR CORRECTION: Twenty-one										

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