DEPARTMENT OF HEALTH

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
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 04/14/2021

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

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F 000	INITIAL COMMENTS On 4/12/21, through 4/14/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: * H5300050C (MN00071656) with deficiencies cited at F550, F677, F686, and F880. * H5300051C (MN00068525) with deficiencies cited at F550, F677, F686, and F880. The following complaint was found to be UNSUBSTANTIATED: * H5300052C (MN00071781) with no deficiencies cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		5/28/21

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

Electronically Signed | 05/14/2021

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F 550	Continued From page 1	F 550		

self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:

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F 550	Continued From page 2 Based on observation, interview, and document review the facility failed to call residents by their preferred name for 1 of 3 (R1) residents who were reviewed for dignity. Findings include: R1's admission Minimum Data Set (MDS) dated 11/9/20, indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition with a diagnosis of cancer. R1's MDS indicated R1 needed extensive assistance with all activities of daily living (ADLs). R3's admission MDS dated 3/23/21, indicated R3 had a BIMS of 13, which indicated intact cognition with diagnoses of pneumonia and acute respiratory failure. R14's admission MDS dated 4/12/21, indicated R14 had a BIMS of 15, which indicated intact cognition with diagnoses of trauma and multiple fractures (broken bones). R14's MDS further indicated moderate assistance with ADLs. During an interview on 4/13/21, at 1:06 p.m. R1 stated nursing assistant (NA)-B "always" called me "hon" and she did not like it. R1 stated she told NA-B not to call her "hon" but NA-B ignored her request and R1 told registered nurse (RN)-D but "nothing changed." During an observation on 4/14/21, at 8:30 a.m. NA-B was observed calling R14 "my friend." During an observation on 4/14/21, at 8:40 a.m. NA-B was observed calling R3 "hon." During an observation on 4/14/21, at 8:45 a.m.	F 550	The policy, □Resident Rights and Notification of Resident Rights□ reviewed and deemed appropriate. R1, R3, and R14 have since discharged the facility. Resident council held on 5/5/21, resident rights specific to use of preferred name and dignity discussed with residents and feedback vocalized by residents provided to IDT team. Facesheets and care plans updated as needed based on resident council feedback. Residents who did not attend resident council will be provided the resident council minutes by Social Services. Facility staff will be educated on the Resident Right policy and use of preferred name as determined by the resident. This education will occur May 20th and 21st, 2021. DON or designee will ensure and monitor compliance. Audits of staff using preferred name will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 550	Continued From page 3 NA-B was observed calling R14 "hon." During an interview on 4/14/21, at 8:50 a.m. NA-B stated he called every woman "hon" and every man "friend." NA-B stated he did not ask permission from the residents before calling them "hon" or "friend" and no residents told him he should not address them that way. During an interview on 4/14/20, at 4:27 p.m. the director of nursing (DON) stated staff should call residents by their preferred name, which was obtained by social services on admission. The DON stated some staff might call residents "hon" as a term of endearment, but if the resident did not like it, they would expect the resident to tell them if they were uncomfortable with it.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to to provide incontinence care to 2 of 3 residents (R4 and R5) and failed to provide weekly baths for 1 of 3 residents (R1) reviewed for assistance with activities of daily living (ADLs) provided to dependent residents. Findings include: INCONTINENCE CARE R4's admission Minimum Data Set (MDS) dated	F 677	The policy □Activities of Daily Living□ was reviewed and deemed appropriate. R 4 has since discharged the facility. R5□s Bowel and Bladder Observations were reviewed and updated as needed. Resident□s care plan was updated as needed based on review of observations as well as the nursing assistant care sheet. All residents who require assist of two for ADLs, had their Bowel and Bladder assessments and care plans reviewed and updated as need.	5/28/21

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F 677	Continued From page 4 3/9/21, indicated R4 had a Brief Interview Mental Status (BIMS) of 8, which indicated moderately impaired cognition and diagnoses of dementia and diabetes. R4's MDS also indicated R4 was always incontinent of bladder and bowel and required assistance of one person with toileting. During an observation on 4/12/21, at 8:45 a.m. in the doorway of R4's room, a strong urine smell came from the room. Nursing assistant (NA)-A went into R4's room with nursing assistant in training (NAT)-A. NA-A stated the smell of urine was strong, adding "this happens a lot, mostly on the night shift." R4 was observed lying in bed and when he stood up, R4's incontinence product was observed to be saturated with dark yellow brown colored urine and was sagging down from the weight of the urine. A white folded sheet, approximately eight inches by eight inches, underneath where R4 had lain, had a dark yellow wet area that smelled of urine. The incontinent product was cold to the touch indicating R4 had likely worn the wet incontinent product for hours. R4's buttocks, inner thighs and groin were reddened. NA-A provided incontinence care and dressed R4 with clean clothes. During an interview on 4/12/21, at 8:55 a.m. NA-A stated the night aides often don't change the soiled incontinent product of the residents and the morning staff would often find residents with soiled incontinent products. NA-A stated when she found residents soiled, she felt "bad" because the residents cannot help the incontinence when it happened. NA-A stated when she found a resident with a strong odor coming from their room, incontinent product appeared to be soiled for a long time, or the resident's skin was reddened, she would	F 677	R1 has since discharged the facility. All residents requiring bathing assistance were reviewed to ensure appropriate bathing schedule in place per resident preference. Resident care plans updated as needed. Nursing staff will be educated on Activities of Daily Living policy as well as the importance of following the resident centered care plan specific to toileting needs. Staff will also be educated on bathing schedules and documentation of bath refusal. This education will occur on May 20th and 21st, 2021. DON or designee will ensure and monitor compliance of following resident toileting care plans as well as auditing of completion of scheduled baths and/or documentation of refusal of scheduled bath. Audits will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 677	Continued From page 5	F 677		

immediately provide incontinence care and notify the nurse.

During an interview on 4/13/21, at 8: 30 a.m. registered nurse (RN-A) stated she found several residents in the last three months whose incontinence product was full of urine and sometimes feces when RN-A started her the day shift. RN-A stated R4's room smelled of urine and the bedding would be soaked with urine. RN -A stated she assessed R4 after NA-A reported R4 was found soaked with urine. RN-A assessed R4's skin and found R4's coccyx, groin, and thighs were reddened. When a resident was found to be incontinent from the previous shift, RN-A took the previous shift's nursing assistant into the resident's room, and coached the nursing assistant on how to appropriately provide incontinence care. RN-A stated this situation occurred with the night shift and RN-A reported this to the nurse manager to address with the individual staff.

R5's admission MDS dated 3/2/21, indicated R5 had a BIMS score of 15, which indicated intact cognition and had diagnoses of cerebral infarction (stroke), and generalized weakness. R5's MDS further indicated R5 needed extensive assistance (two or more people) with all ADLs including toileting, and R5 was always incontinent of bowel and bladder.

R5's care plan dated 3/5/21, indicated R5 needed extensive assistance (two or more people) with activities of daily living which included bathing, grooming, oral cares, transferring, mobility, vision, bowel and bladder. R5's care plan indicated he was incontinent.

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F 677	Continued From page 6	F 677		

R5's Three Day Bladder Monitoring Worksheet dated 1/21/20, through 1/23/20, indicated R5 was able to be continent for 18 hours when toileting assistance occurred or when R5 was offered toileting every two hours.

During an interview on 4/12/21, at 9:00 a.m. R5 stated he needed help getting out of bed and transferring to the toilet. R5 stated he used his call light and waited up to two hours at night to receive assistance from the nursing staff. R5 explained he could keep his incontinent product dry if he did not have to wait for two hours to get assistance.

During an interview on 4/12/21, at 11:30 a.m. licensed practical nurse (LPN)-A stated staffing was sometimes hard at nights and weekends so R5 might have to wait longer because staff were caring for other residents. LPN-A stated because R5 was incontinent and required assistance of two staff for cares and transfers, it would take longer to get two staff to help assist the R5 to the toilet at night.

During an interview 4/13/2021, at 2:00 p.m. registered nurse (RN)-E stated R5 was incontinent of urine. RN-E stated she had not heard complaints from R5 about waiting too long at night for staff to provide toileting assistance.

During an interview on 4/14/21, at 4:33 p.m. the director of nursing (DON) stated incontinence care or toileting should occur according to the resident's care plan. The DON's expectation was for a resident to be toileted or changed as soon as possible. The DON also stated she expected concerns about staff not providing care to a

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F 677	Continued From page 7	F 677		

resident as needed should be addressed by the nurse manager through staff re-education.

SHOWERING AND BATHING

R1's MDS dated 11/9/20, indicated R1 had a 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.

R1's bathing record dated 12/25/20, at 10:44 p.m. indicated R1 received a complete bed bath with assistance of one.

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.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	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.	F 677		
F 686 SS=D	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 by: Based on observation, interview, and document	F 686	The policy □Prevention and Treatment of	5/28/21

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F 686	Continued From page 9 review, the facility failed to follow care planned interventions to heal current pressure ulcers (PU), and prevent new pressure ulcers from forming on 2 of 3 residents (R7 and R8) reviewed for pressure ulcers. Findings include: The National Pressure Injury Advisory Panel defined pressure injury wound descriptions as follows: Stage 2: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 3: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole, undermining and/or tunneling often occur. Depth	F 686	Skin Breakdown was reviewed and remains appropriate. R7 has since expired. R8 had a new Skin Risk w/Braden completed and his care plan, treatment orders, and care sheet were updated to reflect changes. The Wound RN re-assessed wound and as of 5/12/21, wound closed. All residents with pressure wounds will have a new wound care assessment and Skin Risk w/Braden completed. Care plan and treatment orders updated as appropriate based on skin risk and wound assessments. Nursing staff will be educated on the policy Prevention and Treatment of Skin Breakdown , use of care sheet/care plans to determine appropriate repositioning and treatment needed and daily skin checks with cares and weekly skin checks with bathing. NARs will be asked to sign and turn in their care sheet at the end of their shift to show acknowledgement of resident care plans. This education will occur May 20th and 21st, 2021. DON or designee will ensure and monitor compliance. Audits of NAR signed care sheets and repositioning of resident per their care plan will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 686	Continued From page 10 varies by anatomical location. Deep Tissue Pressure Injury; Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal (skin) separation revealing a dark wound bed or blood filled blister. R8's admission Minimum Data Set (MDS) dated 6/3/20, indicated R8 was admitted in June 2020, had diagnoses of Parkinson's disease and was at risk for pressure ulcers. Subsequent quarterly MDS indicated R8 did not have a pressure ulcer until his quarterly MDS dated 3/23/21, when it indicated R8 had developed a pressure ulcer. R8's Care Area Assessment (CAA) dated 6/10/20, indicated R8 needed extensive assistance (two or more staff) with bed mobility, transfers, toileting, and bathing. The incontinence CAA indicated R8 needed staff assistance with pericare, managing incontinence briefs, and indicated R8 was toileted every two hours and upon request with check and change on night rounds. The pressure ulcer CAA indicated R8 was at risk for pressure ulcers and indicated staff were to provide assistance of two staff with bed mobility and repositioning every two hours. R8's care plan dated 6/17/20, indicated R8 was at risk for PU and included interventions of providing assistance of two staff to reposition every two hours, providing incontinence care, using pressure reducing cushions in the wheelchair or chair, using pressure reduction when in bed, and using a moisture barrier product to the perineal area.	F 686		

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The Nursing Assistant Worksheet dated 4/9/21, indicated R8 should receive toileting upon arising, after meals, and at night or per his request.

R8's Skin Risk Assessment completed by RN-A dated 12/16/20, indicated R8 had no PU's.

R8's progress note (PN) dated 2/24/21, indicated R8 had two pressure ulcers on his coccyx but there was no description of the PUs or indication of size.

R8's Event Report dated 2/24/21, indicated R8 developed a new Stage 2 PU with partial thickness loss of skin layers and included mild pain to the area on his coccyx.

R8's PN dated 3/5/21, indicated R8 had a Stage 2 PU measuring 2 centimeters (cm) long by 5 cm wide in size.

R8's wound nurse PN dated 3/17/21, indicated R8 had an unstageable PU on his coccyx measuring 3 cm long by 0.6 cm wide by 0.1 cm deep with 100% slough (dead tissue).

R8's PN dated 3/21/21, indicated R8's had an open area on his coccyx measuring 4.5 cm long by 0.7 cm wide.

R8's Skin Risk Assessment completed by RN-A dated 3/23/21, indicated R8's PU measured 3.0 cm long by 0.8 cm wide by 0.2 cm deep.

R8's wound nurse PN dated 4/1/21, indicated the R8's PU measured 2.5 cm long by 0.5 cm wide by 0.2 cm deep.

During an observation on 4/12/21, at 1:58 p.m.,

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R8 was laying in bed on his back with his legs elevated and the head of the bed at a 30 degree angle. During interview at this time, R8 stated he had a "sore on my butt" that developed after he came to the facility. R8 stated it hurt and he was not sure if it was getting better.

During an interview on 4/12/21, at 4:00 p.m., registered nurse (RN)-A stated staff do not document when residents are turned or how long they are in one position. RN-A also stated was no documentation of turning or repositioning of R8.

During continuous observation on 4/13/21, from 8:57 a.m. through 11:23 a.m., R8 was in his wheelchair and eating breakfast. During this time, R8 ate a continental breakfast, watched television, and at 10:45 a.m., nursing assistant (NA)-E brought R8 a brunch tray. At 10:54 a.m., NA-E stated R8 was still eating so she could not return him to bed. At 11:23 a.m., NA-E and NA-F transferred R8 from the wheelchair to his bed and placed him on his back. R8's brief was not checked nor was he offered toileting during this time.

During an interview on 4/13/21, at 9:09 a.m., R8 stated sitting up in the wheelchair does not hurt his bottom "so much" but it was more sore when he was in bed. R8 stated he would try to get on his side when he was in bed but it was hard for him to do by himself. R8 stated staff would help but he sometime rolled back to his back. R8 stated he could not move himself to his side. R8 stated he was in the wheelchair at 8:30 a.m. that morning because that was when they brought him breakfast.

During an interview on 4/13/21, at 9:16 a.m.,

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NA-E stated she transferred R8 from bed to the wheelchair around 8:15 a.m. and stated R8's position should be changed every two hours but NAs did not document when they repositioned residents, stating, "we just know when it's time to turn." NA-E stated to prevent skin breakdown, R8 was toileted after meals and when he needed it. NA-E stated a cream was applied to R8's perineal area after toileting and then a dressing goes over any open sores. NA-E stated she thought R8 only toileted two to three times a shift. NA-E verified R8 was in the wheelchair for over two hours, almost three hours, and was not repositioned.

During continuous observation on 4/14/21, from 7:28 a.m. through 10:30 a.m. R8 was observed in bed, lying on his back from 7:28 a.m. through 9:52 a.m.; three hours.

During an interview on 4/14/21, at 10:30 a.m., NA-D stated the standard of care was to reposition residents every two hours but "nothing was set." NA-D was unsure how long R8 had been on his back but he was on his back when NA-D began his shift and NA-D speculated R8 was last turned at 7:00 a.m. NA-D stated nursing assistants did not document in the computer and they did not record when a resident was repositioned or for how long they stayed in one position.

During an observation on 4/14/21, at 12:20 p.m. RN-F changed R8's PU dressing and a PU was observed on R8's coccyx about 1.5 cm x 0.5 cm x 0.5 cm and RN-F used a Q-tip to pack the Tegaderm agilnate into the wound. R8 was observed to also have a dark pink excoriation on the inferior aspect of his right buttock. RN-F described the excoriation as the size of a silver

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dollar and was like a "diaper rash of a baby." RN-F described the coccyx wound as a Stage 2 pressure ulcer and stated it was "healing nicely."

During an interview on 4/14/21, at 12:10 p.m., NA-C stated nursing assistants observe resident's skin during care and would report any skin issues to the nurse.

During an interview on 4/14/21, at 2:37 p.m., RN-A stated when a new wound or PU was identified, staff would write an event note and the dietician and wound nurse would be notified. The wound nurse would then evaluate and measure the wound on a weekly basis.

During an interview on 4/14/21, at 4:27 p.m. the director of nursing (DON) verified R8's PU started on 2/24/21, and noted with the next assessment 3/17/21, the PU was unstageable. The DON stated a preference for measurement by the wound nurse for consistency with weekly documentation. The DON stated they tried educating nurses on how to measure PU but they still worried wounds were not being consistently and correctly measured.

R7's quarterly MDS dated 3/20/21, indicated R7 was at risk for pressure ulcers and was always incontinent of bowel and bladder. R7's MDS further indicated R7 required assistance with bed mobility, transfers, toileting, and hygiene.

R7's CAA dated 11/6/20, indicated R7 had an inability to participate in self cares related to weakness and Parkinson' disease with frequent episodes of bowel and bladder incontinence. The CAA indicated staff should provide assistance with toileting, pericare, and managing

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incontinence products.

R7's care plan dated 4/12/21, indicated R7 was at risk for impaired skin integrity and interventions included cleansing the open area on her right gluteal fold with wound cleanser and Calmoseptine lotion.

R7's Event Report for skin integrity pressure sore dated 4/9/21, indicated R7 was found to have a Stage 2 PU on the right gluteal fold which measured 1.5 cm long by 1 cm wide.

R7's wound care order dated on 4/9/21, indicated to observe and assess the right gluteal fold, cleanse with wound cleaner, apply Calmoseptine ointment, and cover with a foam dressing. The wound care order further indicated to change every other day and as needed.

During continuous observation on 4/13/221, from 11:30 a.m. to 2:00 p.m., R7 was observed sitting in the same position in her wheelchair with a cushion on the seat of the wheelchair and was either sleeping or watching television for the entire two and one half hours.

During interview on 4/13/21, at 2:00 p.m. RN-B stated the standard was for residents to be turned or repositioned every two hours. RN-B stated R7 should be laid down in bed after brunch to off load the pressure wound site on her backside. R7 was still up in her wheelchair during this interview.

During interview on 4/14/21, at 4:33 p.m. the DON stated residents should be repositioned per care plan, Braden scale, manager recommendation, and patient recommendation.

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F 686	Continued From page 16 The DON further stated nurses documented in the Treatment Administration Record (TAR) if a resident had position changed during the shift, but it did not indicate what the position change was or the time of the position change. The DON stated we have enough staff to reposition the residents and my expectations was for staff to provide care according to the care plan. The facility's Prevention and Treatment of Skin Breakdown/Pressure Injury policy dated 2018, indicated: 1) skin was observed daily with cares and if there were abnormal findings, it was to be documented in the record; 2) licensed nurses performed a weekly skin audit on all residents and when if a new pressure injury occurred, it was documented in the medical record; and 3) on a weekly basis the license nurse would "stage, measure, and examine the wound bed and surrounding skin." In addition, the policy indicated when a pressure injury occurred, standing orders/protocols for skin impairment were initiated.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		5/28/21

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F 880	Continued From page 17 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 18 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to perform hand hygiene for 4 of 4 residents (R3, R4, R8, and R12), failed to assure shared resident equipment was properly cleaned/disinfected between resident use for 3 of 3 residents (R3, R4, and R12); and failed to assure proper use of gloves to prevent the spread of infections in 1 of 3 residents (R8) reviewed for infection control practices. Finding include: R8's quarterly Minimum Data Set (MDS), dated 3/23/21, indicated R8 had diagnoses of Parkinson's disease, fractured (broken) clavicle, and pressure ulcers. R8's MDS indicated R8 required extensive assistance (two or more staff) with activities of daily living (ADL) including bathing, toileting, personal hygiene, and transfers. During continuous observation on 4/14/21, at 9:34 a.m. through 10:35 a.m. NA-D entered R8's room without performing hand hygiene and assisted R8 with a partial bed bath and donning a	F 880	The policies, □Hand Hygiene□ and □Resident Care Equipment□ were reviewed and deemed appropriate. Facility staff will be educated on the Hand Hygiene and Resident Care Equipment policies and expectations of when to perform hand hygiene, appropriate glove use, as well as when to clean reusable resident care equipment. Employee NA-B was immediately educated on infection control practices including hand hygiene, glove use and cleaning of resident equipment on 4/14 and is currently no longer employed at facility. DON or designee will ensure and monitor compliance. Audits of hand hygiene, glove use, and cleaning of resident care equipment will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after	

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F 880	Continued From page 19 shirt, pants, and socks but leaving soiled adult brief in place. NA-D exited R8's room without performing hand hygiene. NA-D returned to R8's room with NA-C; NA-C performed hand hygiene upon entering the room but NA-D did not perform hand hygiene. Using a transfer belt, NA-C and NA-D stood R8 from a wheelchair; NA-D then donned gloves and removed R8's soiled brief and R8 was transferred to the toilet. NA-D disposed of the soiled brief and his gloves at the same time but did not perform hand hygiene after doffing the gloves. R8 remained seated on the toilet until RN-A arrived to assist.]RN-A entered R8's room without performing hand hygiene and donned gloves to assist NA-C with getting R8 to his feet while NA-D donned gloves and performed perineal care. NA-D doffed the gloves, did not perform hand hygiene, and donned new gloves. NA-D positioned a clean brief on R8. RN-A, NA-C, and NA-D pivoted R8 from the toilet and assisted him back to his wheelchair. RN-A doffed her gloves and exited the room without performing hand hygiene. NA-D wheeled R8 to the sink to assist R8 with oral care, washing and rinsing R8's dentures. NA-D returned R8 to the room and did not perform hand hygiene upon exiting the room. During an interview on 4/14/21, at 10:30 a.m. NA-D stated hand hygiene should be performed when going into a resident's room, during care, and upon exiting the room. NA-D thought he performed hand hygiene between cares but was not sure. R4's admission MDS dated 3/9/21, indicated R4 had diagnoses of diabetes and a gastronomy tube (feeding tube directly inserted into the stomach through the abdomen).	F 880	analysis. See attached DPOC documents.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

R3's admission MDS dated 3/23/21, indicated R3 had diagnoses of pneumonia, chronic kidney disease, diabetes, and sepsis (a systemic infection).

R12's admission MDS dated 4/12/21, indicated R12 had diagnoses of chronic lung disease and chronic kidney disease.

During continuous observations on 4/14/21, from 8:20 a.m. through 8:45 a.m. nursing assistant (NA)-B obtained weights and vital signs on three different residents using the same set of vital sign equipment (blood pressure cuff, pulse oximeter, and thermometer) without cleaning the equipment between residents and without performing hand hygiene:
* NA-B entered R4's room without performing hand hygiene and wheeled R4 from his room to the shower/tub room to obtain R4's weight. NA-B wheeled R4 into the hallway where the vital sign equipment was located. NA-B took R4's blood pressure, pulse, oxygen saturation level, and temperature. NA-B wheeled R4 back to his room. NA-B did not clean the equipment after use on R4 and did not perform hand hygiene.
*NA-B then entered R3's room without performing hand hygiene and wheeled R3 to the shower/tub room to obtain R3's weight. NA-B wheeled R3 into the hallway where the same vital sign equipment was located that had been used with R4. NA-B took R3's vital signs including blood pressure, pulse, oxygen saturation, and temperature. NA-B wheeled R3 back to her room. NA-B did not clean the equpment after use on R3 and did not perform hand hygiene.
*NA-B entered R12's room without performing hand hygiene and took R12 to the shower/tub

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F 880	Continued From page 21	F 880		

room to obtain R12's weight. NA-B wheeled R12 into the hallway where the same vital sign equipment was located that had been used with R4 and R3. NA-B took R12's vital signs including blood pressure, pulse, oxygen saturation, and temperature. NA-B did not clean the equipment after use on R12 and did not perform hand hygiene.

During an interview on 4/14/21, at 8:47 a.m. NA-B stated he did not clean the equipment in between each resident and further confirmed he did not perform hand hygiene between each resident when obtaining vital signs. NA- B stated he did not think he had to wash his hands since he did not perform personal cares such as incontinence care on the resident. NA-B further stated he completed education on Relias (electronic education system) on hand hygiene.

During an interview on 4/14/21, at 4:33 p.m. the director of nursing (DON) stated her expectation was for hand hygiene to be performed when hands are visibly soiled, before and after patient care, removal of personal protective equipment, and after a resident was fed. The DON stated hand hygiene was expected to be done with soap and water or with hand sanitizer. The DON further stated staff would wear gloves when personal cares or treatments were completed. The DON further stated her expectation was medical equipment should be cleaned with a sanitizing wipe in between each resident use.

The facility's Hand Hygiene policy dated 6/17, indicated staff should perform hand hygiene before and after any direct resident contact. The hand hygiene policy further indicated hand hygiene was to be performed when coming into

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F 880	Continued From page 22 contact with a resident's intact skin, such as when taking vitals or after assisting with lifting. The facility's Resident Care Equipment policy, dated 6/17, indicated staff would disinfect reusable equipment between residents using an environmental protection agency (EPA) approved disinfectant.	F 880		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/12/21 through 4/14/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: * H5300050C (MN00071656) with licensing orders issued at 0840, 0900, and 1805. * H5300051C (MN00068525) with licensing orders issued at 0840, 0900, and 1805. The following complaint was found to be UNSUBSTANTIATED: * H5300052C (MN00071781), a related licensing order was issued at 0840, 0900, and 1805. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 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. 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.	2 000		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident,	2 840		5/28/21

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2 840	Continued From page 3 if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to to provide incontinence care to 2 of 3 residents (R4 and R5) and failed to provide weekly baths for 1 of 3 residents (R1) reviewed for assistance with activities of daily living (ADLs) provided to dependent residents. Findings include: INCONTINENCE CARE R4's admission Minimum Data Set (MDS) dated 3/9/21, indicated R4 had a Brief Interview Mental Status (BIMS) of 8, which indicated moderately impaired cognition and diagnoses of dementia and diabetes. R4's MDS also indicated R4 was	2 840	Corrected	

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2 840	Continued From page 4 always incontinent of bladder and bowel and required assistance of one person with toileting. During an observation on 4/12/21, at 8:45 a.m. in the doorway of R4's room, a strong urine smell came from the room. Nursing assistant (NA)-A went into R4's room with nursing assistant in training (NAT)-A. NA-A stated the smell of urine was strong, adding "this happens a lot, mostly on the night shift." R4 was observed lying in bed and when he stood up, R4's incontinence product was observed to be saturated with dark yellow brown colored urine and was sagging down from the weight of the urine. A white folded sheet, approximately eight inches by eight inches, underneath where R4 had lain, had a dark yellow wet area that smelled of urine. The incontinent product was cold to the touch indicating R4 had likely worn the wet incontinent product for hours. R4's buttocks, inner thighs and groin were reddened. NA-A provided incontinence care and dressed R4 with clean clothes. During an interview on 4/12/21, at 8:55 a.m. NA-A stated the night aides often don't change the soiled incontinent product of the residents and the morning staff would often find residents with soiled incontinent products. NA-A stated when she found residents soiled, she felt "bad" because the residents cannot help the incontinence when it happened. NA-A stated when she found a resident with a strong odor coming from their room, incontinent product appeared to be soiled for a long time, or the resident's skin was reddened, she would immediately provide incontinence care and notify the nurse. During an interview on 4/13/21, at 8: 30 a.m. registered nurse (RN-A) stated she found several	2 840		

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2 840	Continued From page 5 residents in the last three months whose incontinence product was full of urine and sometimes feces when RN-A started her the day shift. RN-A stated R4's room smelled of urine and the bedding would be soaked with urine. RN -A stated she assessed R4 after NA-A reported R4 was found soaked with urine. RN-A assessed R4's skin and found R4's coccyx, groin, and thighs were reddened. When a resident was found to be incontinent from the previous shift, RN-A took the previous shift's nursing assistant into the resident's room, and coached the nursing assistant on how to appropriately provide incontinence care. RN-A stated this situation occurred with the night shift and RN-A reported this to the nurse manager to address with the individual staff. R5's admission MDS dated 3/2/21, indicated R5 had a BIMS score of 15, which indicated intact cognition and had diagnoses of cerebral infarction (stroke), and generalized weakness. R5's MDS further indicated R5 needed extensive assistance (two or more people) with all ADLs including toileting, and R5 was always incontinent of bowel and bladder. R5's care plan dated 3/5/21, indicated R5 needed extensive assistance (two or more people) with activities of daily living which included bathing, grooming, oral cares, transferring, mobility, vision, bowel and bladder. R5's care plan indicated he was incontinent. R5's Three Day Bladder Monitoring Worksheet dated 1/21/20, through 1/23/20, indicated R5 was able to be continent for 18 hours when toileting assistance occurred or when R5 was offered toileting every two hours.	2 840		

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2 840	Continued From page 6 During an interview on 4/12/21, at 9:00 a.m. R5 stated he needed help getting out of bed and transferring to the toilet. R5 stated he used his call light and waited up to two hours at night to receive assistance from the nursing staff. R5 explained he could keep his incontinent product dry if he did not have to wait for two hours to get assistance. During an interview on 4/12/21, at 11:30 a.m. licensed practical nurse (LPN)-A stated staffing was sometimes hard at nights and weekends so R5 might have to wait longer because staff were caring for other residents. LPN-A stated because R5 was incontinent and required assistance of two staff for cares and transfers, it would take longer to get two staff to help assist the R5 to the toilet at night. During an interview 4/13/2021, at 2:00 p.m. registered nurse (RN)-E stated R5 was incontinent of urine. RN-E stated she had not heard complaints from R5 about waiting too long at night for staff to provide toileting assistance. During an interview on 4/14/21, at 4:33 p.m. the director of nursing (DON) stated incontinence care or toileting should occur according to the resident's care plan. The DON's expectation was for a resident to be toileted or changed as soon as possible. The DON also stated she expected concerns about staff not providing care to a resident as needed should be addressed by the nurse manager through staff re-education. SHOWERING AND BATHING R1's MDS dated 11/9/20, indicated R1 had a	2 840		

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2 840	Continued From page 7 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. R1's bathing record dated 12/25/20, at 10:44 p.m. indicated R1 received a complete bed bath with assistance of one. 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. 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.	2 840		

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2 840	Continued From page 8 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could educate responsible staff to provide care to residents dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores	2 900		5/28/21

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2 900	Continued From page 9 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow care planned interventions to heal current pressure ulcers (PU), and prevent new pressure ulcers from forming on 2 of 3 residents (R7 and R8) reviewed for pressure ulcers. Findings include: The National Pressure Injury Advisory Panel defined pressure injury wound descriptions as follows: Stage 2: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 3: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue	2 900	Corrected	

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2 900	Continued From page 10 loss this is an Unstageable Pressure Injury. Stage 4: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole, undermining and/or tunneling often occur. Depth varies by anatomical location. Deep Tissue Pressure Injury; Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal (skin) separation revealing a dark wound bed or blood filled blister. R8's admission Minimum Data Set (MDS) dated 6/3/20, indicated R8 was admitted in June 2020, had diagnoses of Parkinson's disease and was at risk for pressure ulcers. Subsequent quarterly MDS indicated R8 did not have a pressure ulcer until his quarterly MDS dated 3/23/21, when it indicated R8 had developed a pressure ulcer. R8's Care Area Assessment (CAA) dated 6/10/20, indicated R8 needed extensive assistance (two or more staff) with bed mobility, transfers, toileting, and bathing. The incontinence CAA indicated R8 needed staff assistance with pericare, managing incontinence briefs, and indicated R8 was toileted every two hours and upon request with check and change on night rounds. The pressure ulcer CAA indicated R8 was at risk for pressure ulcers and indicated staff were to provide assistance of two staff with bed mobility and repositioning every two hours. R8's care plan dated 6/17/20, indicated R8 was at risk for PU and included interventions of providing assistance of two staff to reposition every two	2 900		

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2 900	Continued From page 11 hours, providing incontinence care, using pressure reducing cushions in the wheelchair or chair, using pressure reduction when in bed, and using a moisture barrier product to the perineal area. The Nursing Assistant Worksheet dated 4/9/21, indicated R8 should receive toileting upon arising, after meals, and at night or per his request. R8's Skin Risk Assessment completed by RN-A dated 12/16/20, indicated R8 had no PU's. R8's progress note (PN) dated 2/24/21, indicated R8 had two pressure ulcers on his coccyx but there was no description of the PUs or indication of size. R8's Event Report dated 2/24/21, indicated R8 developed a new Stage 2 PU with partial thickness loss of skin layers and included mild pain to the area on his coccyx. R8's PN dated 3/5/21, indicated R8 had a Stage 2 PU measuring 2 centimeters (cm) long by 5 cm wide in size. R8's wound nurse PN dated 3/17/21, indicated R8 had an unstageable PU on his coccyx measuring 3 cm long by 0.6 cm wide by 0.1 cm deep with 100% slough (dead tissue). R8's PN dated 3/21/21, indicated R8's had an open area on his coccyx measuring 4.5 cm long by 0.7 cm wide. R8's Skin Risk Assessment completed by RN-A dated 3/23/21, indicated R8's PU measured 3.0 cm long by 0.8 cm wide by 0.2 cm deep.	2 900		

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2 900	Continued From page 12	2 900		

R8's wound nurse PN dated 4/1/21, indicated the R8's PU measured 2.5 cm long by 0.5 cm wide by 0.2 cm deep.

During an observation on 4/12/21, at 1:58 p.m., R8 was laying in bed on his back with his legs elevated and the head of the bed at a 30 degree angle. During interview at this time, R8 stated he had a "sore on my butt" that developed after he came to the facility. R8 stated it hurt and he was not sure if it was getting better.

During an interview on 4/12/21, at 4:00 p.m., registered nurse (RN)-A stated staff do not document when residents are turned or how long they are in one position. RN-A also stated was no documentation of turning or repositioning of R8.

During continuous observation on 4/13/21, from 8:57 a.m. through 11:23 a.m., R8 was in his wheelchair and eating breakfast. During this time, R8 ate a continental breakfast, watched television, and at 10:45 a.m., nursing assistant (NA)-E brought R8 a brunch tray. At 10:54 a.m., NA-E stated R8 was still eating so she could not return him to bed. At 11:23 a.m., NA-E and NA-F transferred R8 from the wheelchair to his bed and placed him on his back. R8's brief was not checked nor was he offered toileting during this time.

During an interview on 4/13/21, at 9:09 a.m., R8 stated sitting up in the wheelchair does not hurt his bottom "so much" but it was more sore when he was in bed. R8 stated he would try to get on his side when he was in bed but it was hard for him to do by himself. R8 stated staff would help but he sometime rolled back to his back. R8 stated he could not move himself to his side. R8 stated he was in the wheelchair at 8:30 a.m. that

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2 900	Continued From page 13	2 900		

morning because that was when they brought him breakfast.

During an interview on 4/13/21, at 9:16 a.m., NA-E stated she transferred R8 from bed to the wheelchair around 8:15 a.m. and stated R8's position should be changed every two hours but NAs did not document when they repositioned residents, stating, "we just know when it's time to turn." NA-E stated to prevent skin breakdown, R8 was toileted after meals and when he needed it. NA-E stated a cream was applied to R8's perineal area after toileting and then a dressing goes over any open sores. NA-E stated she thought R8 only toileted two to three times a shift. NA-E verified R8 was in the wheelchair for over two hours, almost three hours, and was not repositioned.

During continuous observation on 4/14/21, from 7:28 a.m. through 10:30 a.m. R8 was observed in bed, lying on his back from 7:28 a.m. through 9:52 a.m.; three hours.

During an interview on 4/14/21, at 10:30 a.m., NA-D stated the standard of care was to reposition residents every two hours but "nothing was set." NA-D was unsure how long R8 had been on his back but he was on his back when NA-D began his shift and NA-D speculated R8 was last turned at 7:00 a.m. NA-D stated nursing assistants did not document in the computer and they did not record when a resident was repositioned or for how long they stayed in one position.

During an observation on 4/14/21, at 12:20 p.m. RN-F changed R8's PU dressing and a PU was observed on R8's coccyx about 1.5 cm x 0.5 cm x 0.5 cm and RN-F used a Q-tip to pack the Tegaderm agilnate into the wound. R8 was

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2 900	Continued From page 14	2 900		

observed to also have a dark pink excoriation on the inferior aspect of his right buttock. RN-F described the excoriation as the size of a silver dollar and was like a "diaper rash of a baby." RN-F described the coccyx wound as a Stage 2 pressure ulcer and stated it was "healing nicely."

During an interview on 4/14/21, at 12:10 p.m., NA-C stated nursing assistants observe resident's skin during care and would report any skin issues to the nurse.

During an interview on 4/14/21, at 2:37 p.m., RN-A stated when a new wound or PU was identified, staff would write an event note and the dietician and wound nurse would be notified. The wound nurse would then evaluate and measure the wound on a weekly basis.

During an interview on 4/14/21, at 4:27 p.m. the director of nursing (DON) verified R8's PU started on 2/24/21, and noted with the next assessment 3/17/21, the PU was unstageable. The DON stated a preference for measurement by the wound nurse for consistency with weekly documentation. The DON stated they tried educating nurses on how to measure PU but they still worried wounds were not being consistently and correctly measured.

R7's quarterly MDS dated 3/20/21, indicated R7 was at risk for pressure ulcers and was always incontinent of bowel and bladder. R7's MDS further indicated R7 required assistance with bed mobility, transfers, toileting, and hygiene.

R7's CAA dated 11/6/20, indicated R7 had an inability to participate in self cares related to weakness and Parkinson' disease with frequent episodes of bowel and bladder incontinence. The

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2 900	Continued From page 15 CAA indicated staff should provide assistance with toileting, pericare, and managing incontinence products. R7's care plan dated 4/12/21, indicated R7 was at risk for impaired skin integrity and interventions included cleansing the open area on her right gluteal fold with wound cleanser and Calmoseptine lotion. R7's Event Report for skin integrity pressure sore dated 4/9/21, indicated R7 was found to have a Stage 2 PU on the right gluteal fold which measured 1.5 cm long by 1 cm wide. R7's wound care order dated on 4/9/21, indicated to observe and assess the right gluteal fold, cleanse with wound cleaner, apply Calmoseptine ointment, and cover with a foam dressing. The wound care order further indicated to change every other day and as needed. During continuous observation on 4/13/221, from 11:30 a.m. to 2:00 p.m., R7 was observed sitting in the same position in her wheelchair with a cushion on the seat of the wheelchair and was either sleeping or watching television for the entire two and one half hours. During interview on 4/13/21, at 2:00 p.m. RN-B stated the standard was for residents to be turned or repositioned every two hours. RN-B stated R7 should be laid down in bed after brunch to off load the pressure wound site on her backside. R7 was still up in her wheelchair during this interview. During interview on 4/14/21, at 4:33 p.m. the DON stated residents should be repositioned per care plan, Braden scale, manager	2 900		

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2 900	Continued From page 16	2 900		

recommendation, and patient recommendation. The DON further stated nurses documented in the Treatment Administration Record (TAR) if a resident had position changed during the shift, but it did not indicate what the position change was or the time of the position change. The DON stated we have enough staff to reposition the residents and my expectations was for staff to provide care according to the care plan.

The facility's Prevention and Treatment of Skin Breakdown/Pressure Injury policy dated 2018, indicated: 1) skin was observed daily with cares and if there were abnormal findings, it was to be documented in the record; 2) licensed nurses performed a weekly skin audit on all residents and when if a new pressure injury occurred, it was documented in the medical record; and 3) on a weekly basis the license nurse would "stage, measure, and examine the wound bed and surrounding skin." In addition, the policy indicated when a pressure injury occurred, standing orders/protocols for skin impairment were initiated.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21805	Continued From page 17	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to call residents by their preferred name for 1 of 3 (R1) residents who were reviewed for dignity. Findings include: R1's admission Minimum Data Set (MDS) dated 11/9/20, indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition with a diagnosis of cancer. R1's MDS indicated R1 needed extensive assistance with all activities of daily living (ADLs). R3's admission MDS dated 3/23/21, indicated R3 had a BIMS of 13, which indicated intact cognition with diagnoses of pneumonia and acute respiratory failure. R14's admission MDS dated 4/12/21, indicated R14 had a BIMS of 15, which indicated intact cognition with diagnoses of trauma and multiple fractures (broken bones). R14's MDS further indicated moderate assistance with ADLs. During an interview on 4/13/21, at 1:06 p.m. R1 stated nursing assistant (NA)-B "always" called	21805	Corrected	5/28/21

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21805	Continued From page 18 me "hon" and she did not like it. R1 stated she told NA-B not to call her "hon" but NA-B ignored her request and R1 told registered nurse (RN)-D but "nothing changed." During an observation on 4/14/21, at 8:30 a.m. NA-B was observed calling R14 "my friend." During an observation on 4/14/21, at 8:40 a.m. NA-B was observed calling R3 "hon." During an observation on 4/14/21, at 8:45 a.m. NA-B was observed calling R14 "hon." During an interview on 4/14/21, at 8:50 a.m. NA-B stated he called every woman "hon" and every man "friend." NA-B stated he did not ask permission from the residents before calling them "hon" or "friend" and no residents told him he should not address them that way. During an interview on 4/14/20, at 4:27 p.m. the director of nursing (DON) stated staff should call residents by their preferred name, which was obtained by social services on admission. The DON stated some staff might call residents "hon" as a term of endearment, but if the resident did not like it, they would expect the resident to tell them if they were uncomfortable with it. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance.	21805		

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21805	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		