DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 11, 2022

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

RE: CCN: 245300
Cycle Start Date: March 11, 2022

Dear Administrator:

On March 23, 2022, we notified you a remedy was imposed. On April 7, 2022 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 April 1, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 7, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 23, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 11, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 1, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Electronically delivered

April 11, 2022

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

Re: Reinspection Results
Event ID: DNHC12

Dear Administrator:

On April 7, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 11, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Electronically Submitted
March 23, 2022

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

RE: CCN: 245300
Cycle Start Date: March 11, 2022

Dear Administrator:

On March 11, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 11, 2022, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

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 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 7, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 7, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 7, 2022, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 11, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Cerenity Care Center - White Bear Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 11, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/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 September 11, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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 64900
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 03/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 3/10/22, through 3/11/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities.

The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F600 began on 2/28/22, when the facility failed to immediately remove a nursing assistance from working after causing suspected mental and verbal abuse to a resident. The administrator and the director of nursing (DON) were notified of the IJ on 3/10/22, at 5:26 p.m. The IJ was removed on 3/11/22, at 1:17 p.m.

The above findings constituted substandard quality of care, and an extended survey was conducted 3/11/22.

At the time of the abbreviated survey, onsite investigations were completed and the following complaint was found to be substantiated : H5300072C (MN81410) with deficiencies cited at F600, F609. An unrelated tag was cited at F843.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.

Upon receipt of an acceptable electronic POC, an

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/01/2022

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.

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F 000	Continued From page 1 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (R1) reviewed for abuse. Nursing assistant (NA)-A mentally and verbally abused R1, was allowed to continue working, and returned to R1's room a second time, mentally and verbally abusing R1 again. This resulted in an immediate jeopardy (IJ). The IJ began on 2/28/22, when NA-A mentally and verbally abused R1. NA-A was allowed to continue working with residents, resulting in a second encounter between NA-A and R1, and	F 600	The policy □Abuse Prevention Plan□ was reviewed and remains appropriate. R1 was interviewed again to ensure they feel safe at the facility and with the care being received. R1□s care plan was reviewed and updated as appropriate. The Nurse and NAR care guides were also updated as appropriate. All interviewable residents were interviewed to determine any concerns with abuse or neglect, these interviews did not identify any further concerns.	4/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 2 NA-A again mentally and verbally abused R1. NA-A was allowed to continue working following both incidents. The administrator and the director of nursing (DON) were notified of the IJ on 3/10/22, at 5:26 p.m. The IJ was removed on 3/11/22, at 1:17 p.m. when it was verified an acceptable removal plan was implemented. Findings include: R1's Diagnosis List printed on 3/14/22, indicated R3 had diagnosis of cerebral infarction, low back pain, diabetes, and depression. R1's admission MDS dated 3/3/22, indicated he was cognitively impaired. The admission MDS also indicated R1 required extensive assistance for bed mobility, transfers, and locomotion, and required partial to moderate assist with toileting. The MDS also indicated R1 was cognitively intact. R1's care plan printed on 3/14/22, lacked indication of how R1 required staff assistance with toileting. On 2/28/22, at 12:49 p.m. a facility report to the State Agency (SA) indicated on 2/28/22, at approximately 1:30 a.m. nursing assistant (NA)-A mentally and verbally abused R1. A facility investigation into the incident indicated the following: On 2/28/22, NA-A's written statement indicated she answered R1's call light that night, and he was wet after trying to use the urinal himself. NA-A wrote that she told R1 to cover himself up so she could go and get more help, as he was an assist of two.	F 600	Residents who were non-interviewable had a medical chart review completed by a licensed staff and primary unit staff were interviewed; these reviews and interviews did not identify any concerns with abuse or neglect. NA-A is no longer employed by the facility. Staff of all departments and shifts were educated and interviewed on the VA process including what is abuse and neglect, immediate reporting when suspicion of abuse is identified as well as ensuring resident safety by immediately removing the staff identified in the concern. This education will be completed by 4/1/22. The updated VA education was also added to the new hire orientation process & onboarding of supplemental staff. DON or designee will ensure and monitor compliance. Audits of resident interviews will occur 3x/week for 3 months to ensure residents are free from abuse and neglect. 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 600	Continued From page 3	F 600		

NA-B wrote she returned from her break, answered R1's call light that was ringing again, and changed him while NA-A was in another room providing cares.

On 2/28/22, NA-B's written statement indicated R1's call light was on when she returned from her break on 2/28/22, at 2:10 a.m. NA-B documented all of R1's bedding was soaked with urine. R1 told NA-B earlier he had put his call light on and NA-A had came to his room and he asked her to change him. R1 told NA-B that NA-A told him someone would be down to change him later, after she refused to change him. R1 told NA-B he pressed the call light about 20 minutes after NA-A had left the room, and that is when NA-B arrived. NA-B indicated she had gone into multiple resident rooms where the residents told her NA-B had not helped them when they turned on their call lights. NA-B documented NA-A was just sitting at the nursing station, turning off call lights. NA-B indicated at around 4:00 a.m. she was finishing her charting, and NA-A again turned off a call light, and stated she was tired as she had been working two floors.

On 2/28/22, LPN-A's written statement indicated she went to R1's room at 3:03 a.m. and R1 stated he had used his call light, and NA-B answered the call light. R1 stated NA-A had answered his call light and turned it off, after she saw he was wet. R1 stated NA-A then just walked out of his room. LPN-A said R1 stated he wasn't sure if she was coming back or not, so he pressed his call light again and NA-B came to his room and changed him. LPN-A indicated NA-B reported the incident to LPN-A. LPN-A indicated she approached

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F 600	Continued From page 4	F 600		

NA-A, and told her there had been a complaint made by R1. LPN-A asked NA-A to write a statement regarding the incident, and NA-A declined stating she did not want to incriminate herself in writing. LPN-A indicated she told NA-A not to return to R1's room. Around 4:10 a.m. R1's light was on, and NA-A was walking down the hall to answer R1's call light. LPN-A told NA-A to stop and not to enter R1's room. LPN-A then went into R1's room and R1 was trembling and asked LPN-A to shut the door as NA-A was standing behind LPN-A in the doorway. R1 told LPN-A he was woken up later by NA-A, and she interrogated him about the earlier incident. R1 stated he had asked NA-A to leave the room twice. LPN-A indicated R1 was crying and told LPN-A he was afraid to use his call light after the incident because he was afraid NA-A would respond to it. R1 stated he felt threatened by NA-A. LPN-A documented she repeatedly apologized to R1 for NA-A's rudeness and behavior.

On 3/2/22, the director of nursing (DON)'s written statement indicated education was done with LPN-A specific to removing staff from the schedule after receiving allegations of neglect. The DON discussed the incident with R1 with LPN-A, and told her NA-A should have been sent home immediately after it had been identified NA-A returned to R1's room after being instructed not to. NA-A was not sent home after either incident.

On 3/10/22, on 11:53 a.m. R1 was interviewed with family member (FM)-A present. R1 stated the night of 2/28/22, he tried to use his hand-held urinal, but urinated on himself. R1 stated he used his call light and NA-A came to his room, shut off

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	245300	A. BUILDING _____ B. WING _____	C 03/11/2022

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

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F 600	Continued From page 5	F 600		

his call light, and threw the sheets and blankets off him. R1 stated when she saw he was wet, NA-A told him she would tell someone to change him, and then left the room. R1 stated after about 20 minutes, he used his call light again, and NA-B came in and changed him. R1 stated he was upset with the situation with NA-A, and wanted to speak to the nurse. R1 stated LPN-A came into his room and took his statement, and he told her he was upset and fearful of NA-A. R1 stated LPN-A told him not to worry, as NA-A would not be working with him anymore. R1 stated later that night, NA-A did returned to his room. R1 stated NA-A said she was there to set the record straight and, "I'm going to tell you what happened." R1 stated he was very fearful after the encounter and was afraid to use his call button fearful NA-A would return. R1 stated LPN-A returned to his room after NA-A had left, and he told her he was upset NA-A had returned to his room for a second time. R1 stated the scariest part of the incidents was the intimidation factor used by NA-A.

On 3/10/22, at 12:55 p.m. NA-B was interviewed. NA-B stated the night of 2/28/22, she was on break from approximately 1:30 a.m. to 2:00 a.m. NA-B stated she returned from her break, and at approximately 2:10 a.m. she responded to R1's call light. NA-B stated nobody had told her R1 needed help. NA-B stated she changed R1, he was tearful and thankful, and stated NA-A had scared him. NA-B stated she reported this to LPN-A who went and talked to R1. NA-B stated NA-A was asked to write statement about the incident, and was told she was to stay out of R1's room. NA-B stated later in the night, R1's light was on again, and she saw NA-A returning from R1's hallway, and thought NA-A had possibly been in R1's room. NA-B stated NA-A's version of

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F 600	Continued From page 6	F 600		

events were not adding up.

On 3/10/22, at 1:19 p.m. LPN-A was interviewed and stated she was made aware of the concerns with NA-A by NA-B after R1's first allegation. LPN-A stated R1 told her about the situation, and was very upset. LPN-A stated she spent 30 minutes apologizing and calming R1 down. LPN-A stated she tried to reassure R1 by telling him NA-A would not be returning to his room. LPN-A stated she asked NA-A to write a statement about what had happened, LPN-A stated NA-A only wrote three or four lines, and was extremely aggressively defensive toward her. LPN-A stated she told NA-A not to return to R1's room. LPN-A stated later, she went back to check on R1, and R1 told her NA-A had returned to his room. LPN-A stated R1 told her he was still fearful NA-A would return to his room. LPN-A stated she should have sent NA-A home after the first incident.

On 3/10/22, at 2:52 p.m. the DON was interviewed. The DON stated LPN-A should have sent NA-A home after the first incident, because then the second incident wouldn't have happened. The DON stated NA-A absolutely should have been taken off the floor after the second time she returned to R1's room. The DON stated she was informed of the incident at 7:00 a.m. on 2/28/22.

R1's progress notes lacked any indication of the incidents on 2/28/22.

The facility policy Freedom from Abuse Prevention Plan dated 2017, directed abuse is the willful infliction of injury, reasonable confinement, intimidation, or punishment with resulting in

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F 600	Continued From page 7 physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. This includes verbal abuse, sexual abuse, and mental abuse.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		4/1/22

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F 609	Continued From page 8 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours, to the State Agency for 1 of 3 residents (R1) reviewed for abuse. Findings include: On 2/28/22, at 12:49 p.m. a facility report to the State Agency (SA) indicated on 2/28/22, at approximately 1:30 a.m. nursing assistant (NA)-A mentally and verbally abused R1. The report was submitted approximately 11 hours and 19 minutes after the the alleged abuse. R1's Diagnosis List printed on 3/14/22, indicated R3 had diagnosis of cerebral infarction, low back pain, diabetes, and depression. R1's admission Minimum Data Set (MDS) dated 3/3/22, indicated he was cognitively impaired. The admission MDS also indicated R1 required extensive assistance for bed mobility, transfers, and locomotion, and was a partial to moderate assist with toileting. The MDS also indicated R1 was cognitively intact. On 3/10/22, on 11:53 a.m. R1 was interviewed with family member (FM)-A present. R1 stated the night of 2/28/22, he tried to use his hand-held urinal, but urinated on himself. R1 stated he used his call light and NA-A came to his room, shut off his call light, and threw the sheets and blankets off him. R1 stated when she saw he was wet, NA-A told him she would tell someone to change	F 609	The □Abuse Prevention Plan□ was reviewed and remains appropriate. R1□s care plan was reviewed and updated as appropriate. Resident was interviewed again to ensure they feel safe at the facility and with care being received. Staff of all departments and shifts were educated and interviewed on the VA process including what is abuse and neglect and immediate reporting when suspicion of abuse is identified. These interviews identified no further concerns with abuse or neglect. The education and staff interviews will be completed by April 1st. The updated VA education was also added to the new hire orientation process & onboarding of supplemental staff. DON or designee will ensure and monitor compliance. Staff interview audits will occur specific to abuse/neglect to ensure staff members are competent with VA awareness, protocols, and reporting expectations. These audits will occur occur 3x per week x2 weeks, weekly x 2 weeks, and 3x 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 609	Continued From page 9	F 609		

him, and then left the room. R1 stated after about 20 minutes, he used his call light again, and NA-B came in and changed him. R1 stated he was upset with the situation with NA-A, and wanted to speak to the nurse. R1 stated LPN-A came into his room and took his statement, and he told her he was upset and fearful of NA-A. R1 stated LPN-A told him not to worry, as NA-A would not be working with him anymore. R1 stated later that night, NA-A did returned to his room. R1 stated NA-A said she was there to set the record straight and, "I'm going to tell you what happened." R1 stated he was very fearful after the encounter and was afraid to use his call button fearful NA-A would return. R1 stated LPN-A returned to his room after NA-A had left, and he told her he was upset NA-A had returned to his room for a second time. R1 stated the scariest part of the incidents was the intimidation factor used by NA-A.

On 3/10/22, at 1:19 p.m. LPN-A was interviewed and stated she was made aware of the concerns with NA-A by NA-B after R1's first allegation. LPN-A stated R1 told her about the situation, and was very upset. LPN-A stated she spent 30 minutes apologizing and calming R1 down. LPN-A stated she tried to reassure R1 by telling him NA-A would not be returning to his room. LPN-A stated she asked NA-A to write a statement about what had happened, LPN-A stated NA-A only wrote three or four lines, and was extremely aggressively defensive toward her. LPN-A stated she told NA-A not to return to R1's room. LPN-A stated later, she went back to check on R1, and R1 told her NA-A had returned to his room. LPN-A stated R1 told her he was still fearful NA-A would return to his room. LPN-A stated she should have sent NA-A home after the first incident. LPN-A also stated she should have

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F 609	Continued From page 10 reported the incident to the DON after it occurred. On 3/10/22, at 2:52 p.m. the DON was interviewed. The DON stated the incident should have been reported immediately. The DON stated she was not notified until 7:00 a.m. the morning of 2/28/22. The facility Freedom from Abuse Prevention Plan, copyright dated 2017, indicated abuse must be reported to the SA immediately, but no later than two hours after it occurs.	F 609		
F 843 SS=C	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including	F 843		4/1/22

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F 843	Continued From page 11 but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and/or have evidence of a transfer agreement with a local Medicare/Medicaid participating hospital entity. This had potential to affect all 138 residents in the facility who could require hospitalization on an emergent basis. Findings include: During the extended survey on 3/10/22, to 3/11/22, documentation was requested from the director of nursing (DON) to demonstrate the facility had a transfer agreement in place with a local Medicare/Medicaid participating hospital entity. On 3/11/22, at 1:45 p.m. interviewed the DON who stated the facility could not locate a transfer agreement and would check with their corporate office. The facility was unable to produce a transfer agreement.	F 843	No one Resident was found to be negatively affected by this deficiency noted upon extended survey review. The facility has identified any current or newly admitted Resident to the community to have the potential to be affected by the absence of a readily accessible transfer agreement with a hospital. The measures put in place to correct the deficiency are the following: Education was provided to the Administrator and DON on the importance of having an active and present transfer agreement in place with a hospital. A Hospital Transfer Agreement was constructed and presented to a local Medicare/Medicaid participating hospital partner for full agreement execution between entities. An audit on the presence of an executed transfer agreement will occur weekly for 1 month and then monthly for 2 months to ensure there is a readily accessible hospital transfer agreement present within the community. Negative findings will be corrected immediately with appropriate action. Findings will be reviewed at	

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F 843	Continued From page 12	F 843	monthly Quality Council for ongoing monitoring/audit continuation. Administrator/Designee is responsible.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 23, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: DNHC11

Dear Administrator:

The above facility was surveyed on March 10, 2022 through March 11, 2022 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	00923	A. BUILDING: _____ B. WING _____	C 03/11/2022

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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 3/10/22, through 3/11/22 a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H55300072C (MN81410) with a licensing order issued at 4658.0050 Subp 3.E 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 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> 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 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	2 000		

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2 000	Continued From page 2 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		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	21980		4/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	C 03/11/2022

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

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21980	Continued From page 3 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours, to the State Agency for 1 of 3 residents (R1) reviewed for abuse. Findings include: On 2/28/22, at 12:49 p.m. a facility report to the State Agency (SA) indicated on 2/28/22, at approximately 1:30 a.m. nursing assistant (NA)-A mentally and verbally abused R1. The report was submitted approximately 11 hours and 19 minutes after the the alleged abuse. R1's Diagnosis List printed on 3/14/22, indicated	21980	Corrected	

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21980	Continued From page 4 R3 had diagnosis of cerebral infarction, low back pain, diabetes, and depression. R1's admission Minimum Data Set (MDS) dated 3/3/22, indicated he was cognitively impaired. The admission MDS also indicated R1 required extensive assistance for bed mobility, transfers, and locomotion, and was a partial to moderate assist with toileting. The MDS also indicated R1 was cognitively intact. On 3/10/22, on 11:53 a.m. R1 was interviewed with family member (FM)-A present. R1 stated the night of 2/28/22, he tried to use his hand-held urinal, but urinated on himself. R1 stated he used his call light and NA-A came to his room, shut off his call light, and threw the sheets and blankets off him. R1 stated when she saw he was wet, NA-A told him she would tell someone to change him, and then left the room. R1 stated after about 20 minutes, he used his call light again, and NA-B came in and changed him. R1 stated he was upset with the situation with NA-A, and wanted to speak to the nurse. R1 stated LPN-A came into his room and took his statement, and he told her he was upset and fearful of NA-A. R1 stated LPN-A told him not to worry, as NA-A would not be working with him anymore. R1 stated later that night, NA-A did returned to his room. R1 stated NA-A said she was there to set the record straight and, "I'm going to tell you what happened." R1 stated he was very fearful after the encounter and was afraid to use his call button fearful NA-A would return. R1 stated LPN-A returned to his room after NA-A had left, and he told her he was upset NA-A had returned to his room for a second time. R1 stated the scariest part of the incidents was the intimidation factor used by NA-A. On 3/10/22, at 1:19 p.m. LPN-A was interviewed	21980		

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21980	Continued From page 5	21980		

and stated she was made aware of the concerns with NA-A by NA-B after R1's first allegation. LPN-A stated R1 told her about the situation, and was very upset. LPN-A stated she spent 30 minutes apologizing and calming R1 down. LPN-A stated she tried to reassure R1 by telling him NA-A would not be returning to his room. LPN-A stated she asked NA-A to write a statement about what had happened, LPN-A stated NA-A only wrote three or four lines, and was extremely aggressively defensive toward her. LPN-A stated she told NA-A not to return to R1's room. LPN-A stated later, she went back to check on R1, and R1 told her NA-A had returned to his room. LPN-A stated R1 told her he was still fearful NA-A would return to his room. LPN-A stated she should have sent NA-A home after the first incident. LPN-A also stated she should have reported the incident to the DON after it occurred.

On 3/10/22, at 2:52 p.m. the DON was interviewed. The DON stated the incident should have been reported immediately. The DON stated she was not notified until 7:00 a.m. the morning of 2/28/22.

The facility Freedom from Abuse Prevention Plan, copyright dated 2017, indicated abuse must be reported to the SA immediately, but no later than two hours after it occurs.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could develop, review, and/or revise policies and procedures regarding reporting abuse.
The administrator or designee could educate all appropriate staff on the policies, procedures of reporting abuse.
The administrator or designee could develop monitoring systems to ensure ongoing

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21980	Continued From page 6 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		