Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 12, 2023

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

RE: CCN: 245300
Cycle Start Date: August 25, 2023

Dear Administrator:

On October 4, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

An equal opportunity employer.

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October 12, 2023

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

Re: Reinspection Results
Event ID: EY7K12

Dear Administrator:

On October 4, 2023 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 August 25, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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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Administrator
Cerenity Care Center White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: CCN: 245300
Cycle Start Date: August 25, 2023

Dear Administrator:

On August 25, 2023, 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 attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 25, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 25, 2024 (six months after

the identification of noncompliance) your provider agreement will be terminated. 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.

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, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 08/25/2023

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 8/22/23 to 8/25/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The following complaints were reviewed:
H53004697C (MN00096134) with deficiency issued at F802,
H53004774C (MN00096158) with deficiencies cited at F676, F677, F686.

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 that substantial compliance with the regulations has been attained.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		10/2/23

§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/15/2023

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 676	Continued From page 1 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ambulate with 1 of 1 resident (R2) reviewed for restorative nursing. Findings include: R2's annual Minimum Data Set (MDS) dated, 7/28/23, indicated intact cognition, and required supervision with one-person physical assistance for ambulation in room. The MDS further indicated non-completion of any restorative	F 676	The facility policy, Activities of Daily Living was reviewed and remains appropriate. R2s ambulation program was reviewed and updated. R2s care plan, ambulation order, and CNA care guide were updated to reflect changes. The signature sheet in R2s room was removed and all documentation will be recorded in the residents electronic medical record.	

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F 676

Continued From page 2

nursing activities for R2 during the assessment period.

R2's care plan identified R2 as alert and oriented and able to communicate his needs, wants and concerns. The approach was to allow R2 to voice needs, wants, and concerns. The care plan indicated R2 was unable to ambulate independently related to unsteady gait and balance. The care plan directed staff to call family when R2 refuses ambulation, to monitor and document R2's participation in restorative programs, to do a monthly review and evaluation about the progression and need to change the program, and to implement the restorative nursing program, where R2 will ambulate at least twice daily, preferably to all destinations using contact guard assist (CGA) with a gait belt.

The treatment order dated 2/10/23, directed staff to walk with R2 twice a day as tolerated, CGA with gait belt. The treatment order also directed staff to sign ambulation program sheet in R2's room.

An ambulation program sheet posted in R2's room indicated R2 ambulated on 8/10/23 at the afternoon shift, on 8/11/23 at the afternoon shift, on 8/14/23 at the afternoon shift, and on 8/22/23 at the morning shift.

The treatment administration record (TAR) dated 7/24/23 through 8/23/23 showed seven days when R2 ambulated twice in a day, eight days when R2 ambulated once a day, and 16 days when R2 did not ambulate at all. The TAR documented the reasons for not completing the task including refusal (14 times), went to activity/unavailable (4 times), walked with family

F 676

All residents with ambulation programs will have their programming reviewed for appropriateness and will be updated as needed. If changes are made the residents care plan and care guides will be updated.

Licensed nurses and CNAs will be educated on the Activities of Daily Living policy. This includes the importance of following and completing ambulation programs, documentation of refusals and/or completed ambulation programs.

The DON or designee will ensure and monitor compliance. Audits of ambulation program compliance and documentation will be completed 3x per week for 2 weeks, weekly for 2 weeks, 3x per month x 2 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 676	Continued From page 3	F 676		

Continued From page 3
(3 times), and did not get done/floor busy (9 times).

During observation and interview on 8/23/23 at 12:56 p.m., R2 stated he was supposed to be walked twice a day, but it was not being done. R2 stated, "They're busy." R2 said, "somebody walked with me once yesterday." At 2:22 p.m., R2 denied that he ever refused ambulation. R2 further said, "I will walk with them [staff] if they asked."

During interview on 8/23/23 at 2:36 p.m., NA-A stated that there are tasks such as baths and ambulation being missed because the unit is very demanding with call lights, and many residents use Hoyer lifts. NA-A verified R2 on ambulation program and needed to be walked twice a day. NA-A continued to say, "but a lot of times don't, we just can't, we're busy."

During interview on 08/24/23 at 2:30 p.m., NA-C stated, "[R2] is supposed to be walked two times a day but sometimes it is not done, he is walking really slow." NA-C also stated sometimes they would not have time to ambulate residents.

During interview on 8/24/23 at 4:00 p.m., the director of nursing (DON) verified that R2 was not ambulated as scheduled. The DON also acknowledged the importance of following restorative therapy orders.

During interview on 8/25/23 at 11:35 a.m., the director of rehabilitation services (DRS) stated that restorative nursing "is an important piece on keeping mobility and function." The DRS stated expectation that restorative care recommendations are being followed.

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F 676	Continued From page 4 The policy no. RNS_001, titled, BHS Restorative Program, provides the basic outline and guidance for implementation and tracking of restorative programs established so that each resident can "attain and maintain highest physical, mental and psychosocial wellbeing". The policy indicates that restorative nursing promotes resident's highest level of independence in certain areas including ambulation and mobility. The policy also provides that therapy will develop written plan recommending restorative interventions. The policy directs the therapist to collaborate with the registered nurse, the resident, the resident's responsible party, or other designated facility associate for the implementation of the plan. The policy also indicates that the written plan includes frequency and duration, and specific instructions on how to implement the restorative nursing plan.	F 676		
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 ensure assistance with wearing compression socks for 1 of 1 resident (R2) reviewed for dressing. Findings include: R2's face sheet listed R2's diagnoses including ankylosing spondylitis of cervicothoracic region (damage to the spine), coronary atherosclerosis	F 677	The facility policy, Activities of Daily Living was reviewed and remains appropriate. Facility staff provided a new pair of TED stockings to R2 on 9/7/23. R2s TED stocking order was edited to provide clarity and the care plan was updated to reflect occasional refusal of TEDs. R2s care guide was updated to include to	10/2/23

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F 677

Continued From page 5

(narrowing of the arteries) due to lipid rich plaque, benign prostatic hyperplasia with urinary obstruction, chronic kidney disease, and carcinoma in situ of the skin of trunk.

R2's annual Minimum Data Set (MDS) dated, 7/28/23, indicated intact cognition, and needed supervision with one-person physical assistance with dressing.

R2's care area assessment (CAA) triggered for activities of daily living (ADLs).

R2's care plan indicated that R2 is alert and oriented and able to communicate needs, wants, and concerns. The care plan indicated for allowing R2 to voice his needs, wants, and concerns. The care plan also indicated R1 had self-care deficit, and the care plan directed staff to assist with dressing.

The orders dated 12/16/23, indicated R2 needed to wear knee high TEDS (compression socks), which should be put on during the daytime and off at nighttime.

The treatment administration record (TAR) dated 8/23 indicated that R2 wore or had TEDS on most of the days of the month, including on 8/22/23 and 8/23/23. However, this record for 8/22/23 and 8/23/23 conflicted with the observations and information from interviews as noted below.

During observation on 8/22/23 at 3:51 p.m., R2 was at the common TV area, talking with 2 other residents. R2 did not have TEDS on.

During observation and interview on 8/23/23 at 12:56 p.m., R2 was not wearing TEDS. R2 stated

F 677

update the nurse if the resident refuses TED stockings.

All residents with a TED stocking order were audited to ensure they had TED stockings available for wear. Resident□s physician order and care plans were updated to reflect use as needed.

CNAs and nurses will be educated on the importance of following physician orders for use of TED stockings and how to handle refusal of care.

The DON or designee will ensure and monitor compliance. Audits of compliance with TED stocking orders will be completed 3x per week for 2 weeks, weekly for 2 weeks, 3x per month x 2 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 6 he was supposed to wear TEDS but did not have them on for "a month now" saying that "they could not find them." R2 stated that when staff took his clothes to the laundry, they included the TEDS and were never brought back, and none was put on since. During interview on 8/23/23 at 3:14 p.m., RN-C stated R2 had been refusing to wear his TEDS. RN-C and RN-B verified that R2, who was at the dining room playing BINGO at the time, was not wearing TEDS. During interview on 8/24/23 at 4:00 p.m., the director of nursing (DON) acknowledged the importance of following treatment orders, and the importance of documentation to monitor and evaluate effectiveness of interventions. The policy titled, Comprehensive Assessments and Care Planning, with latest review date of 7/2/18, directs all qualified staff to implement all person-centered care plans. The policy indicates that interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.	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	F 686		10/2/23

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F 686	Continued From page 7 (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 interview and record review, the facility did not ensure completion of wound treatment as ordered for 1 of 1 resident (R2) reviewed for pressure ulcer. Findings include: R2's annual MDS dated, 7/28/23, indicated R2's stage two pressure ulcer. The MDS also indicated R2 was undergoing pressure ulcer care. R's care plan, dated 7/25/23, identified a pressure ulcer/shearing on R2's right shoulder from lying on the same area. The care plan directed staff to assess and treat the pressure ulcer as ordered. The history of treatment orders for R2's pressure ulcer on right shoulder are as follows: -Started on 2/22/23 and discontinued (dc/d) on 7/25/23 - Mepilex dressing every 7 days, once a day on Monday from 2:30 p.m. to 10:30 p.m. -Started on 7/26/23 and dc/d on 7/25/23 - Tegaderm dressing every other day at 9:00 a.m. -Started on 7/25/23 and dc/d on 8/2/23 - Apply xeroform gauze and cover with dressing every other day until healed at 9:00 a.m. -Started on 8/2/23 and dc/d on 8/7/23 - Change dressing every 5 days, cleanse well with soap and	F 686	The policy Prevention and Treatment of Skin Breakdown was reviewed and remains appropriate. R2 had a new Skin Risk with Braden completed and his care plan and care sheet were updated to reflect any changes. The Wound RN re-assessed the residents wound and as of 9/13/23, the wound was observed to be closed with non-blanchable redness where open area previously was. RN updated Dermatologist on 9/15/23 with wound nurses observation to ensure treatment remains appropriate. All residents with pressure wounds will have a new wound care assessment and Skin Risk with Braden completed. Care plan and treatment orders will be updated as appropriate based on skin risk and wound assessments. Nursing staff will be educated on the policy Prevention and Treatment of Skin Breakdown and the importance of following physician orders. DON or designee will ensure and monitor compliance. Audits of wound care compliance will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3	

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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 686	Continued From page 8	F 686		

water before dressing placed, use Mepilex dressing.

-Started on 8/7/23 and current - Change dressing ever 5 days, cleanse well with soap and water before dressing placed. Use Mepilex dressing.

The Treatment Administration Record (TAR) dated 6/23/23 to 8/23/23 showed that staff did not consistently follow the orders for pressure ulcer treatments, as follows:

-The order for Mepilex dressing every 7 days on Mondays which was in place until discontinuation on 7/25/23, the records show R2 received treatments on 6/26/23, 7/3/23, 7/17/23, but did not receive treatments on 7/10/23, and 7/24/23. The record indicates R2 went without wound treatment for 14 days from 7/3/23 to 7/17/23.

-The order on 7/25/23 to apply xeroform gauze and cover with dressing every other day until healed at 9:00 a.m., the records show R2 was on this treatment on 7/27/23, 7/31/23, and 8/2/23. R2 did not receive treatment on 7/29/23. The order was discontinued on 8/2/23.

-The order to use Mepilex dressing and change every 5 days, cleanse well with soap and water before dressing placed, which was ordered on 8/2/23, showed that the treatment did not start until 8/7/23. The records also show staff did not provide wound treatments as scheduled on 8/17/23 and 8/22/23.

R2's medication orders include an antibiotic, doxycycline hyclate capsule 100 milligrams (mg) twice a day that started 8/8/23 to 8/22/23.

Provider's plan of correction (F 686):

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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	245300	A. BUILDING ______ B. WING ______	C 08/25/2023

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F 686	Continued From page 9	F 686		

The progress notes showed that on 8/8/23, R2's family brought a bottle of antibiotic from dermatology clinic stating that R2's laboratory results showed staphylococcus (bacterial) infection.

During interview on 8/25/23 at 11:32 a.m., registered nurse (RN)-D, identified self as the wound nurse who takes care of R2's pressure wound on right shoulder. RN-D stated R2's pressure wound was chronic and "stagnant at this point." RN-D also stated she was not aware about R2's wound infection and that she was not treating an infection to the wound. RN-D indicated that the dermatology clinic oversees ordering treatments for the wound to include dressing changes. RN-D stated that both the facility staff nurses and herself are to follow wound care orders. RN-D emphasized that although she visits residents and would do wound care, hers should be an extra dressing change or wound care, and staff are still expected to follow wound care/dressing changes as scheduled.

During interview on 8/25/23 at 12:23 p.m., the nurse practitioner (NP) stated that R2's family are the ones who informed the facility about the infection on R2's right shoulder wound. The NP indicated she did not review test results, nor did she get a report from dermatology about the infection. The NP stated she was not aware that treatments orders for R2's wound were not consistently implemented.

During interview on 8/25/23 at 2:44 p.m., RN-E identified herself as the nurse with the dermatologist. RN-E confirmed they saw R2 on 8/1/23 and did a culture on the right scapula wound, which showed positive for bacterial

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F 686	Continued From page 10 infection. RN-E stated their office prescribed doxycycline 100 mg twice a day for 2 weeks. RN-E also stated a possible cause of the infection could be failure to complete wound dressings regularly. The policy no. POL_NS1702, titled, Prevention and Treatment of Skin Breakdown/Pressure Injury, undated, indicates under its purpose statement that maintaining intact skin is integral to resident health and wellness. The statement also indicates that care and service are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. The policy provides that residents who experience break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. The policy lists the guidelines to be followed if a resident has impaired skin integrity including evaluation of pressure reduction intervention and revise patient-centered care plan, and notification to the attending provider, resident/resident representative and supervisor if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly, and re-evaluation of the plan of care as appropriate.	F 686		
F 802 SS=D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment	F 802		10/2/23

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F 802	Continued From page 11 required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with nutritional services for 3 of 4 residents (R1, R2, and R6) reviewed for dining. Findings include: R1's quarterly Minimum Data Set (MDS), dated 8/2/23, indicated R1 was totally dependent on staff for activities of daily living (ADLs) including eating. The MDS identified R1's weight as 97 pounds and indicated R1 lost weight of 5% or more within the last month, 10 % or more within the last 6 months. The MDS also indicated R1 was on mechanically altered diet. R1's care plan identified a focus area related to R1's difficulty to make self-understood and to understand others due to severe cognitive impairment. The care plan described R1 as non-verbal and does not make needs known. The care plan directed staff to implement the following approaches, including communication and provision of liquids and food as needed, and anticipation of R1's needs. The care plan also identified R1's altered nutritional status as	F 802	The facility policy, ‘Comprehensive Assessments and Care Planning’ was reviewed and remains appropriate. R1, R2, and R6’s most recent nutritional assessments and care plans were reviewed and updated as appropriate. R2 and R6 care plans were updated to reflect the ability to choose to not have a protein option with breakfast per preference. Kitchenettes will continue to be stocked with nutritionally balanced options for breakfast to allow access to these items for R2, R6, and other residents after meal service. All residents who require feeding assistance had their care plan and nutritional assessment reviewed. Nutritional assessments and care plans were updated as appropriate. Nursing staff will be educated on the importance of following the nutritional assessment and care plan related to culinary preferences. Nursing staff and	

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F 802	Continued From page 12 evidenced by weight loss, and due to chewing/swallowing difficulty, self-feeding difficulty, and insufficient oral intake at meals. The care plan indicated R1's weight loss of more than 10 % in 6 months. The care plan directed staff to implement approaches that include help with set-up and physical assistance during meals, to encourage R1 to eat slowly, and to monitor and record R1's food intake. R1's meal intake records for the last 3 months (5/24/23 through 8/22/23), showed that R1 did not have regular breakfast meals, as follows: -From 5/24/23 to 5/31/23 (eight days), there were three breakfast meals and the average intakes noted on: 5/29/23 at 1-25%, 5/30/23 at 1-25%, and 5/31/23 at 51-75%. -From 6/1/23 to 6/30/23 (30 days), there were two breakfast meals and the average intakes noted on: 6/6/23 at 26-50%, and 6/8/23 at 26-50%. -From 7/1/23 to 7/31/23 (31 days), there were eight breakfast meals and the average intakes noted on: 7/1/23 with 51-75%, 7/6/23 with 1-25%, 7/7/23 with 1-25%, 7/9/23 with 51-75%, 7/10/23 with 26-50%, 7/13/23 with 1-25%, 7/19/23 with 1-25%, 7/27/23 with 1-25%. -From 8/1/23 to 8/22/23 (22 days), there were two breakfast meals and the average intakes noted on: 8/1/23 with 76-100%, and 8/10/23 with 1-25%. During observations on 8/23/23 at 8:40 a.m., R1 was in her room, lying in bed, awake and moving her head. -From 8:42 a.m. to 9:18 a.m., nursing assistant (NA)-A entered R1's room and talked to R1 about	F 802	culinary staff will be educated on proper restriction of residents from the kitchenette area with the use of the installed gate and availability of nutritionally balanced options in kitchenettes after meal service. Food items during meal service will be kept in the kitchenette behind the gate. DON or designee will ensure and monitor compliance. Audits of nutritional care plan compliance will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3 times per month x2 months. Audits of kitchenette gate use and food being kept behind the counter/gate will be audited 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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getting ready for the day. NA-A completed morning cares and then NA-B came in to help transfer R1 from bed to her wheelchair (with reclining back), and then NA-A pushed R1's chair to the common TV area in front of the nurses' station at 9:25 a.m.
-At 9:27 a.m. NA-A brought R1's food for breakfast, identified as "pancake" and thickened apple juice. NA-A started feeding R1.
-At 9:32 a.m., NA-A stopped feeding R1, stood up holding the leftover food and drink, and started to walk towards the main dining room. NA-A stated R1 kept her mouth closed that indicated R1 did not want any more food. NA-A also stated R1 took sips of the apple juice and about 50% of the pancake. NA-A added that it would take an hour or more to feed R1 and that her husband always "comes here to feed her."

During an interview on 8/22/23 at 4:31 p.m. FM-A stated observations that "the facility is very short with workers and cannot feed residents during breakfast." FM-A added that "some residents at dining" reported to him that staff would only give R1 "a couple of bites" and that would be it for breakfast. FM-A stated he feels the need to be at the facility to feed R1 lunch and dinner, saying with the reports that he gets, he was unsure if R1 was being fed her breakfast.

During an interview on 8/23/23 at 12:17 p.m., registered nurse (RN)-A identified herself as R1's hospice nurse and stated that R1 had been declining within the last year, mainly losing weight. RN-A stated that it takes long time for R1 to eat and was probably exerting more effort in eating than her intakes. RN-A stated R1's husband was here almost everyday spending six hours with her.

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During an interview on 8/24/23 at 2:30 p.m., NA-C described R1 as very difficult to feed, and that feeding would take a long time.

R2's annual MDS dated, 7/28/23, indicated intact cognition, supervision with one-person physical assistance for dressing, and independent with set-up assistance for eating.

R2's care area assessment (CAA) triggered for nutritional status and ADLs.

R2's care plan indicated alteration in nutrition due to difficulty swallowing and increased need for protein related to having pressure wound on shoulder and cancer of the skin and trunk. The care plan directed staff to implement approaches including set-up for meals.

During observation on 8/23/23 at 9:17 a.m., R2 was observed moving per wheelchair, in the hallway from his room and towards the common television (TV) area. R2 proceeded to the dining room and went straight to the beverage cart in front of the kitchen counter and poured coffee for himself. R2 also picked a piece of bread from the kitchen countertop, and took a napkin from the counter top, and moved self to a table to eat and drink. There was no staff member in the dining area.

During observation on 8/25/23 at 9:06 a.m., R2 went through the dining room and into the kitchenette, looking and moving around in the area. R6, who was alone eating at one table and looking at R2 stated that R2 "always does that going there looking for food" indicating R2 goes behind the kitchen counter. R6 also said, "We

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help ourselves because there's no one around most of the time." R6 further stated that however, residents should only get food from the front of the kitchenette counter and not go inside the kitchenette or go past the counter like R2 did.

During observation on 8/25/23 at 9:08 a.m., the director of nursing (DON) entered the dining area and approached R2, who indicated he wanted a cup of hot chocolate. The DON helped with R2's request and served a cup of drink to R2 at a table by the piano in the dining room. When the DON left the dining area at about 9:10 a.m., R2 went back to the kitchenette counter and took a muffin and returned to his table to eat.

No observation was made of R2 receiving a balanced breakfast including protein or other food groups.

R6's quarterly MDS dated 7/27/23, indicated moderate cognitive impairment. The MDS indicated R6 was independent but needed help for set-up during meals.

During observation on 8/25/23 at 9:01 a.m., R6 was eating by herself at a table in the dining room. R6 went towards the kitchenette and stopped at the beverage cart, which was parked in front of the kitchenette counter, and poured herself a glass of milk. There was no staff around at the dining area. On 8/25/23 at 9:06 a.m., R6 indicated residents help themselves for breakfast because most of the time, there was no staff around.

No observation was made of R6 receiving a balanced breakfast including protein or other food groups.

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During interview on 8/23/23 at 9:07 a.m., RN-B stated that "it is impossible" for two NAs and one nurse to get all the 24 residents in this unit up before 9:00 a.m. because many residents use lift devices, which also require two persons to use them. RN-B said the NAs do morning cares to prepare residents up for the day, and then we have to answer the call lights in between. RN-B also stated by 9:00 a.m., the culinary aide leaves "this unit" to go serve other units, so nursing staff are then expected to prepare and serve breakfast to the residents they get up. RN-B further stated, "Aside from doing nursing cares, we do dining as well if we have time, but we can't do it all."

During interview on 8/25/23 at 2:05 p.m., the administrator verified that some of the mobile residents go to the beverage cart and get drinks for themselves and also pick up bread from the tray set on the kitchen counter top. The administrator stated expectations that staff members should be the ones preparing and serving food and drinks to the residents.

During interview on 8/25/23 at 2:23 p.m., the DON verified she prepared and served chocolate drink for R2, who was then looking for food and drink at about 9:08 a.m., when there was no other staff in the dining room.

The policy titled, Comprehensive Assessments and Care Planning, with latest review date of 7/2/18, directs all qualified staff to implement all person-centered care plans. The policy indicates that interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: EY7K11

Dear Administrator:

The above facility was surveyed on August 22, 2023 through August 25, 2023 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334.

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

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2 000	Initial Comments	2 000		

*****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 8/22/23 to 8/25/23, a complaint survey was conducted at your facility by surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H53004697C (MN00096134) with a licensing orders issued at 0985, H53004774C (MN00096158) with licensing orders issued at 0900, 0915, 0920. 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	2 000		

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2 000	Continued From page 2 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		
2 900	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 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 interview and record review, the facility did not ensure completion of wound treatment as ordered for 1 of 1 resident (R2) reviewed for pressure ulcer. Findings include:	2 900	Corrected	10/2/23

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2 900	Continued From page 3 R2's annual MDS dated, 7/28/23, indicated R2's stage two pressure ulcer. The MDS also indicated R2 was undergoing pressure ulcer care. R's care plan, dated 7/25/23, identified a pressure ulcer/shearing on R2's right shoulder from lying on the same area. The care plan directed staff to assess and treat the pressure ulcer as ordered. The history of treatment orders for R2's pressure ulcer on right shoulder are as follows: -Started on 2/22/23 and discontinued (dc/d) on 7/25/23 - Mepilex dressing every 7 days, once a day on Monday from 2:30 p.m. to 10:30 p.m. -Started on 7/26/23 and dc/d on 7/25/23 - Tegaderm dressing every other day at 9:00 a.m. -Started on 7/25/23 and dc/d on 8/2/23 - Apply xeroform gauze and cover with dressing every other day until healed at 9:00 a.m. -Started on 8/2/23 and dc/d on 8/7/23 - Change dressing every 5 days, cleanse well with soap and water before dressing placed, use Mepilex dressing. -Started on 8/7/23 and current - Change dressing ever 5 days, cleanse well with soap and water before dressing placed. Use Mepilex dressing. The Treatment Administration Record (TAR) dated 6/23/23 to 8/23/23 showed that staff did not consistently follow the orders for pressure ulcer treatments, as follows: -The order for Mepilex dressing every 7 days on Mondays which was in place until discontinuation	2 900		

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2 900	Continued From page 4	2 900		

on 7/25/23, the records show R2 received treatments on 6/26/23, 7/3/23, 7/17/23, but did not receive treatments on 7/10/23, and 7/24/23. The record indicates R2 went without wound treatment for 14 days from 7/3/23 to 7/17/23.

-The order on 7/25/23 to apply xeroform gauze and cover with dressing every other day until healed at 9:00 a.m., the records show R2 was on this treatment on 7/27/23, 7/31/23, and 8/2/23. R2 did not receive treatment on 7/29/23. The order was discontinued on 8/2/23.

-The order to use Mepilex dressing and change every 5 days, cleanse well with soap and water before dressing placed, which was ordered on 8/2/23, showed that the treatment did not start until 8/7/23. The records also show staff did not provide wound treatments as scheduled on 8/17/23 and 8/22/23.

R2's medication orders include an antibiotic, doxycycline hyclate capsule 100 milligrams (mg) twice a day that started 8/8/23 to 8/22/23.

The progress notes showed that on 8/8/23, R2's family brought a bottle of antibiotic from dermatology clinic stating that R2's laboratory results showed staphylococcus (bacterial) infection.

During interview on 8/25/23 at 11:32 a.m., registered nurse (RN)-D, identified self as the wound nurse who takes care of R2's pressure wound on right shoulder. RN-D stated R2's pressure wound was chronic and "stagnant at this point." RN-D also stated she was not aware about R2's wound infection and that she was not treating an infection to the wound. RN-D indicated that the dermatology clinic oversees ordering

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2 900	Continued From page 5 treatments for the wound to include dressing changes. RN-D stated that both the facility staff nurses and herself are to follow wound care orders. RN-D emphasized that although she visits residents and would do wound care, hers should be an extra dressing change or wound care, and staff are still expected to follow wound care/dressing changes as scheduled. During interview on 8/25/23 at 12:23 p.m., the nurse practitioner (NP) stated that R2's family are the ones who informed the facility about the infection on R2's right shoulder wound. The NP indicated she did not review test results, nor did she get a report from dermatology about the infection. The NP stated she was not aware that treatments orders for R2's wound were not consistently implemented. During interview on 8/25/23 at 2:44 p.m., RN-E identified herself as the nurse with the dermatologist. RN-E confirmed they saw R2 on 8/1/23 and did a culture on the right scapula wound, which showed positive for bacterial infection. RN-E stated their office prescribed doxycycline 100 mg twice a day for 2 weeks. RN-E also stated a possible cause of the infection could be failure to complete wound dressings regularly. The policy no. POL_NS1702, titled, Prevention and Treatment of Skin Breakdown/Pressure Injury, undated, indicates under its purpose statement that maintaining intact skin is integral to resident health and wellness. The statement also indicates that care and service are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. The policy provides that residents who experience break in skin integrity or wounds are provided	2 900		

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2 900	Continued From page 6 care and service to heal the skin according to professional standards of care. The policy lists the guidelines to be followed if a resident has impaired skin integrity including evaluation of pressure reduction intervention and revise patient-centered care plan, and notification to the attending provider, resident/resident representative and supervisor if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly, and re-evaluation of the plan of care as appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should 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 should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 915		10/2/23

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2 915	Continued From page 7 A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ambulate with 1 of 1 resident (R2) reviewed for restorative nursing. Findings include: R2's annual Minimum Data Set (MDS) dated, 7/28/23, indicated intact cognition, and required supervision with one-person physical assistance for ambulation in room. The MDS further indicated non-completion of any restorative nursing activities for R2 during the assessment period. R2's care plan identified R2 as alert and oriented and able to communicate his needs, wants and concerns. The approach was to allow R2 to voice needs, wants, and concerns. The care plan indicated R2 was unable to ambulate independently related to unsteady gait and	2 915	Corrected	

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2 915	Continued From page 8	2 915		

Continued From page 8

balance. The care plan directed staff to call family when R2 refuses ambulation, to monitor and document R2's participation in restorative programs, to do a monthly review and evaluation about the progression and need to change the program, and to implement the restorative nursing program, where R2 will ambulate at least twice daily, preferably to all destinations using contact guard assist (CGA) with a gait belt.

The treatment order dated 2/10/23, directed staff to walk with R2 twice a day as tolerated, CGA with gait belt. The treatment order also directed staff to sign ambulation program sheet in R2's room.

An ambulation program sheet posted in R2's room indicated R2 ambulated on 8/10/23 at the afternoon shift, on 8/11/23 at the afternoon shift, on 8/14/23 at the afternoon shift, and on 8/22/23 at the morning shift.

The treatment administration record (TAR) dated 7/24/23 through 8/23/23 showed seven days when R2 ambulated twice in a day, eight days when R2 ambulated once a day, and 16 days when R2 did not ambulate at all. The TAR documented the reasons for not completing the task including refusal (14 times), went to activity/unavailable (4 times), walked with family (3 times), and did not get done/floor busy (9 times).

During observation and interview on 8/23/23 at 12:56 p.m., R2 stated he was supposed to be walked twice a day, but it was not being done. R2 stated, "They're busy." R2 said, "somebody walked with me once yesterday." At 2:22 p.m., R2 denied that he ever refused ambulation. R2 further said, "I will walk with them [staff] if they

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2 915	Continued From page 9 asked." During interview on 8/23/23 at 2:36 p.m., NA-A stated that there are tasks such as baths and ambulation being missed because the unit is very demanding with call lights, and many residents use Hoyer lifts. NA-A verified R2 on ambulation program and needed to be walked twice a day. NA-A continued to say, "but a lot of times don't, we just can't, we're busy." During interview on 08/24/23 at 2:30 p.m., NA-C stated, "[R2] is supposed to be walked two times a day but sometimes it is not done, he is walking really slow." NA-C also stated sometimes they would not have time to ambulate residents. During interview on 8/24/23 at 4:00 p.m., the director of nursing (DON) verified that R2 was not ambulated as scheduled. The DON also acknowledged the importance of following restorative therapy orders. During interview on 8/25/23 at 11:35 a.m., the director of rehabilitation services (DRS) stated that restorative nursing "is an important piece on keeping mobility and function." The DRS stated expectation that restorative care recommendations are being followed. The policy no. RNS_001, titled, BHS Restorative Program, provides the basic outline and guidance for implementation and tracking of restorative programs established so that each resident can "attain and maintain highest physical, mental and psychosocial wellbeing". The policy indicates that restorative nursing promotes resident's highest level of independence in certain areas including ambulation and mobility. The policy also provides that therapy will develop written plan	2 915		

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2 915	Continued From page 10 recommending restorative interventions. The policy directs the therapist to collaborate with the registered nurse, the resident, the resident's responsible party, or other designated facility associate for the implementation of the plan. The policy also indicates that the written plan includes frequency and duration, and specific instructions on how to implement the restorative nursing plan. SUGGESTED METHOD OF CORRECTION: The director of nursing 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.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance with wearing compression socks for 1 of 1 resident (R2) reviewed for dressing.	2 920	Corrected	10/2/23

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2 920	Continued From page 11	2 920		

Findings include:

R2's face sheet listed R2's diagnoses including ankylosing spondylitis of cervicothoracic region (damage to the spine), coronary atherosclerosis (narrowing of the arteries) due to lipid rich plaque, benign prostatic hyperplasia with urinary obstruction, chronic kidney disease, and carcinoma in situ of the skin of trunk.

R2's annual Minimum Data Set (MDS) dated, 7/28/23, indicated intact cognition, and needed supervision with one-person physical assistance with dressing.

R2's care area assessment (CAA) triggered for activities of daily living (ADLs).

R2's care plan indicated that R2 is alert and oriented and able to communicate needs, wants, and concerns. The care plan indicated for allowing R2 to voice his needs, wants, and concerns. The care plan also indicated R1 had self-care deficit, and the care plan directed staff to assist with dressing.

The orders dated 12/16/23, indicated R2 needed to wear knee high TEDS (compression socks), which should be put on during the daytime and off at nighttime.

The treatment administration record (TAR) dated 8/23 indicated that R2 wore or had TEDS on most of the days of the month, including on 8/22/23 and 8/23/23. However, this record for 8/22/23 and 8/23/23 conflicted with the observations and information from interviews as noted below.

During observation on 8/22/23 at 3:51 p.m., R2

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2 920	Continued From page 12	2 920		

was at the common TV area, talking with 2 other residents. R2 did not have TEDS on.

During observation and interview on 8/23/23 at 12:56 p.m., R2 was not wearing TEDS. R2 stated he was supposed to wear TEDS but did not have them on for "a month now" saying that "they could not find them." R2 stated that when staff took his clothes to the laundry, they included the TEDS and were never brought back, and none was put on since.

During interview on 8/23/23 at 3:14 p.m., RN-C stated R2 had been refusing to wear his TEDS. RN-C and RN-B verified that R2, who was at the dining room playing BINGO at the time, was not wearing TEDS.

During interview on 8/24/23 at 4:00 p.m., the director of nursing (DON) acknowledged the importance of following treatment orders, and the importance of documentation to monitor and evaluate effectiveness of interventions.

The policy titled, Comprehensive Assessments and Care Planning, with latest review date of 7/2/18, directs all qualified staff to implement all person-centered care plans. The policy indicates that interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.

SUGGESTED METHOD OF CORRECTION:
The director of nursing 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

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2 920	Continued From page 13 hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 985	MN Rule 4658.0610 Subp. 1 Dietary Staff Requirements Sufficient personn Subpart 1. Sufficient personnel. The nursing home must employ sufficient personnel competent to carry out the functions of the dietary service. "Sufficient personnel" means enough staff to plan, prepare, and serve palatable, attractive, and nutritionally adequate meals at proper temperatures and appropriate times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with nutritional services for 3 of 4 residents (R1, R2, and R6) reviewed for dining. Findings include: R1's quarterly Minimum Data Set (MDS), dated 8/2/23, indicated R1 was totally dependent on staff for activities of daily living (ADLs) including eating. The MDS identified R1's weight as 97 pounds and indicated R1 lost weight of 5% or more within the last month, 10 % or more within the last 6 months. The MDS also indicated R1 was on mechanically altered diet. R1's care plan identified a focus area related to R1's difficulty to make self-understood and to understand others due to severe cognitive impairment. The care plan described R1 as	2 985	Corrected	10/2/23

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2 985	Continued From page 14	2 985		

non-verbal and does not make needs known. The care plan directed staff to implement the following approaches, including communication and provision of liquids and food as needed, and anticipation of R1's needs. The care plan also identified R1's altered nutritional status as evidenced by weight loss, and due to chewing/swallowing difficulty, self-feeding difficulty, and insufficient oral intake at meals. The care plan indicated R1's weight loss of more than 10 % in 6 months. The care plan directed staff to implement approaches that include help with set-up and physical assistance during meals, to encourage R1 to eat slowly, and to monitor and record R1's food intake.

R1's meal intake records for the last 3 months (5/24/23 through 8/22/23), showed that R1 did not have regular breakfast meals, as follows:

-From 5/24/23 to 5/31/23 (eight days), there were three breakfast meals and the average intakes noted on: 5/29/23 at 1-25%, 5/30/23 at 1-25%, and 5/31/23 at 51-75%.

-From 6/1/23 to 6/30/23 (30 days), there were two breakfast meals and the average intakes noted on: 6/6/23 at 26-50%, and 6/8/23 at 26-50%.

-From 7/1/23 to 7/31/23 (31 days), there were eight breakfast meals and the average intakes noted on: 7/1/23 with 51-75%, 7/6/23 with 1-25%, 7/7/23 with 1-25%, 7/9/23 with 51-75%, 7/10/23 with 26-50%, 7/13/23 with 1-25%, 7/19/23 with 1-25%, 7/27/23 with 1-25%.

-From 8/1/23 to 8/22/23 (22 days), there were two breakfast meals and the average intakes noted on: 8/1/23 with 76-100%, and 8/10/23 with 1-25%.

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	00923	A. BUILDING: ___ B. WING ___	C 08/25/2023

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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During observations on 8/23/23 at 8:40 a.m., R1 was in her room, lying in bed, awake and moving her head.
-From 8:42 a.m. to 9:18 a.m., nursing assistant (NA)-A entered R1's room and talked to R1 about getting ready for the day. NA-A completed morning cares and then NA-B came in to help transfer R1 from bed to her wheelchair (with reclining back), and then NA-A pushed R1's chair to the common TV area in front of the nurses' station at 9:25 a.m.
-At 9:27 a.m. NA-A brought R1's food for breakfast, identified as "pancake" and thickened apple juice. NA-A started feeding R1.
-At 9:32 a.m., NA-A stopped feeding R1, stood up holding the leftover food and drink, and started to walk towards the main dining room. NA-A stated R1 kept her mouth closed that indicated R1 did not want any more food. NA-A also stated R1 took sips of the apple juice and about 50% of the pancake. NA-A added that it would take an hour or more to feed R1 and that her husband always "comes here to feed her."

During an interview on 8/22/23 at 4:31 p.m. FM-A stated observations that "the facility is very short with workers and cannot feed residents during breakfast." FM-A added that "some residents at dining" reported to him that staff would only give R1 "a couple of bites" and that would be it for breakfast. FM-A stated he feels the need to be at the facility to feed R1 lunch and dinner, saying with the reports that he gets, he was unsure if R1 was being fed her breakfast.

During an interview on 8/23/23 at 12:17 p.m., registered nurse (RN)-A identified herself as R1's hospice nurse and stated that R1 had been declining within the last year, mainly losing weight. RN-A stated that it takes long time for R1

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to eat and was probably exerting more effort in eating than her intakes. RN-A stated R1's husband was here almost everyday spending six hours with her.

During an interview on 8/24/23 at 2:30 p.m., NA-C described R1 as very difficult to feed, and that feeding would take a long time.

R2's annual MDS dated, 7/28/23, indicated intact cognition, supervision with one-person physical assistance for dressing, and independent with set-up assistance for eating.

R2's care area assessment (CAA) triggered for nutritional status and ADLs.

R2's care plan indicated alteration in nutrition due to difficulty swallowing and increased need for protein related to having pressure wound on shoulder and cancer of the skin and trunk. The care plan directed staff to implement approaches including set-up for meals.

During observation on 8/23/23 at 9:17 a.m., R2 was observed moving per wheelchair, in the hallway from his room and towards the common television (TV) area. R2 proceeded to the dining room and went straight to the beverage cart in front of the kitchen counter and poured coffee for himself. R2 also picked a piece of bread from the kitchen countertop, and took a napkin from the counter top, and moved self to a table to eat and drink. There was no staff member in the dining area.

During observation on 8/25/23 at 9:06 a.m., R2 went through the dining room and into the kitchenette, looking and moving around in the area. R6, who was alone eating at one table and

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looking at R2 stated that R2 "always does that going there looking for food" indicating R2 goes behind the kitchen counter. R6 also said, "We help ourselves because there's no one around most of the time." R6 further stated that however, residents should only get food from the front of the kitchenette counter and not go inside the kitchenette or go past the counter like R2 did.

During observation on 8/25/23 at 9:08 a.m., the director of nursing (DON) entered the dining area and approached R2, who indicated he wanted a cup of hot chocolate. The DON helped with R2's request and served a cup of drink to R2 at a table by the piano in the dining room. When the DON left the dining area at about 9:10 a.m., R2 went back to the kitchenette counter and took a muffin and returned to his table to eat.

No observation was made of R2 receiving a balanced breakfast including protein or other food groups.

R6's quarterly MDS dated 7/27/23, indicated moderate cognitive impairment. The MDS indicated R6 was independent but needed help for set-up during meals.

During observation on 8/25/23 at 9:01 a.m., R6 was eating by herself at a table in the dining room. R6 went towards the kitchenette and stopped at the beverage cart, which was parked in front of the kitchenette counter, and poured herself a glass of milk. There was no staff around at the dining area. On 8/25/23 at 9:06 a.m., R6 indicated residents help themselves for breakfast because most of the time, there was no staff around.

No observation was made of R6 receiving a

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balanced breakfast including protein or other food groups.

During interview on 8/23/23 at 9:07 a.m., RN-B stated that "it is impossible" for two NAs and one nurse to get all the 24 residents in this unit up before 9:00 a.m. because many residents use lift devices, which also require two persons to use them. RN-B said the NAs do morning cares to prepare residents up for the day, and then we have to answer the call lights in between. RN-B also stated by 9:00 a.m., the culinary aide leaves "this unit" to go serve other units, so nursing staff are then expected to prepare and serve breakfast to the residents they get up. RN-B further stated, "Aside from doing nursing cares, we do dining as well if we have time, but we can't do it all."

During interview on 8/25/23 at 2:05 p.m., the administrator verified that some of the mobile residents go to the beverage cart and get drinks for themselves and also pick up bread from the tray set on the kitchen counter top. The administrator stated expectations that staff members should be the ones preparing and serving food and drinks to the residents.

During interview on 8/25/23 at 2:23 p.m., the DON verified she prepared and served chocolate drink for R2, who was then looking for food and drink at about 9:08 a.m., when there was no other staff in the dining room.

The policy titled, Comprehensive Assessments and Care Planning, with latest review date of 7/2/18, directs all qualified staff to implement all person-centered care plans. The policy indicates that interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.

Minnesota Department of Health

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2 985	Continued From page 19 SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure dietary needs for residents are assessed and staff are implementing care planned assistance for all meals in a timely manner. The facility should review and/or update or create policies and procedures, and educate staff on specific requirements or interventions related to weight and nutrition. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are implemented as identified or ordered. The facility should report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 985		