DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 9, 2020

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: CCN: 245255
Cycle Start Date: July 31, 2020

Dear Administrator:

On October 20, 2020, we notified you remedies were imposed. On November 7, 2020 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 November 6, 2020.

As authorized by CMS the remedy of:

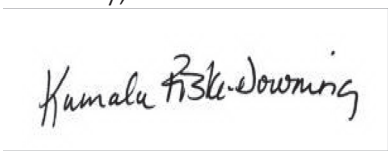
- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 16, 2020 be discontinued as of November 6, 2020. (42 CFR 488.417 (b))

In our letter of August 17, 2020, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 16, 2020. 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,



Kamala Fiske-Downing
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

Electronically delivered
September 10, 2020

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: CCN: 245255
Cycle Start Date: July 31, 2020

Dear Administrator:

On August 17, 2020, we informed you of imposed enforcement remedies.

On August 28, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 16, 2020, will remain in effect.

This Department continues to recommend 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 September 16, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 16, 2020.

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.

As we notified you in our letter of August 17, 2020, in accordance with Federal law, as specified in the

Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 16, 2020.

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 31, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ 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.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE SAINT PAUL, MN 55107**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/25/20, to 8/28/20, an abbreviated standard survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5255071C Deficiency issued at F Tag 609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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	F 609		9/28/20

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

Electronically Signed | 09/18/2020

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 609	Continued From page 1 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 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 immediately reported (no later than 2 hours) to the State Agency (SA) for 1 of 3 residents (R3) reviewed for allegations of potential abuse. Findings include: R3's annual Minimum Data Set (MDS) dated 6/30/20, identified R3 was cognitively intact and had diagnoses which included heart failure, Diabetes Mellitus, respiratory failure and anxiety. The MDS indicated R3 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, toileting, bathing, dressing and grooming. R3's annual care area assessment (CAA) dated 7/13/20, identified R3 had intact cognition and	F 609	The submission of this Plan of Correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing Cerenity Care Center at Humboldt good faith, the facility offers the following Plan of Correction and has achieved substantial compliance in each of the areas addressed on 8/25/20 through 8/28/2020. 1) How corrective action will be accomplished for those residents found to be affected: It is the practice of Cerenity Care Center at Humboldt to ensure that the residents of Cerenity Care Center receive treatment	

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F 609	Continued From page 2 had respiratory failure, heart failure, Diabetes Mellitus and anxiety. The CAA identified R3 required extensive assistance with most ADL's which included bed mobility, toileting, bathing, dressing, grooming and transferred with the use of a mechanical lift. R3's care plan revised 8/17/20, indicated R3 had a potential alteration in cognitive impairment related to cognitive scores that fluctuated. R3's care plan indicated R3 had a history of refusing cares and reporting rough treatment by staff. The care plan instructed staff to provide support as needed, actively involve R3 in her care and allow R3 choices. R3's care plan identified R3 had a self care deficit related to impaired mobility and required extensive assistance with most ADL's which included bathing, dressing, grooming, toileting, and bed mobility. R3's care plan indicated R3 did not walk and required the use of a mechanical lift for transfers. Review of late entry progress note on 3/25/20, at 1:08 p.m. R3 reported to staff she had some care concerns and notifications were completed. A copy of the facility's internal incident report was requested and was not provided. Review of the SA Nursing Home Incident Report (NHIR), revealed the allegation occurred at 3/25/20, at 2:00 a.m. and the allegation was reported to the SA on 3/25/20, at 4:34 p.m., 14 1/2 hours after the allegation had occurred. On 8/26/20, at 11:19 a.m. director of nursing (DON) indicated staff were expected to report all allegations of abuse immediately to a manager, DON, licensed social worker (LSW) or the	F 609	and care in accordance with professional standards of practice for Vulnerable Adult reporting. 2) How to identify other residents having the potential to be affected by the same practice: Residents that reside at Cerenity Care Center Humboldt are vulnerable adults. Residents that reside at Cerenity Care Center Humboldt have been reviewed and no incidents are noted that require reporting. The Vulnerable Adult policy and procedure has been reviewed and it remains current. 3) Measures put into place or systemic changes made to ensure practice will not recur: All staff will be reeducated on the Vulnerable Adult policy and procedure. Education for all staff will include: who is a vulnerable adult, who is a mandated reported, definitions of abuse and neglect, reporting requirements and timelines, protection and prevention of abuse and/or neglect. Nurse managers or designees will review all nursing notes daily for vulnerable adult concerns and to ensure timeliness of reporting. 4) How the facility will monitor its corrective actions to ensure that the practice is being corrected and will not recur: The facility will complete staff knowledge audits on Vulnerable Adult policy and procedure. Audit include who to report VA	

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F 609	Continued From page 3 administrator and one of them would file a report to the SA within two hours. DON stated the facility was notified of R3's allegation of abuse sometime on the day shift on 3/25/20, and was not able to provide an exact time. DON reviewed R3's late entry progress note dated 3/25/20, at 1:08 p.m. and confirmed the allegation had not been reported to the SA within the two hour time frame. On 8/26/20, at 11:52 a.m. nursing assistant (NA)-A stated she worked the 6:30 a.m. to 3:00 p.m. shift on 3/25/20, and confirmed when she provided cares to R3 that morning, R3 informed her she had been beat up by staff during the night. NA-A stated she immediately informed the charge nurse working that day of the allegation of abuse. NA-A stated she was aware all allegations of abuse were expected to be reported immediately. NA-A stated she routinely provided cares to R3 between 10:30 a.m. to 11:00 a.m. most mornings. On 8/26/20, at 12:01 p.m. the administrator stated she expected all allegations of abuse were to be reported immediately to LSW or designee and they would file the report to the SA within two hours. The administrator confirmed R3's allegation of abuse was not reported within two hours to the SA. Review of facility policy titled Abuse Prevention Plan undated instructed staff to immediately report the allegation of abuse to the person in charge and to report to the SA within two hours.	F 609	to, examples of types of abuse/exploitation/neglect, who is a mandated reporter, responsibilities of mandated reporter, timeliness of reporting and what to do to ensure resident safety. Audits will be completed 5 times per week for 4 weeks, then 3 times per week for 3 weeks, then 2 times per week for 2 weeks to ensure ongoing compliance. The results of these audits will forward to the QAPI committee for review and the committee will determine when compliance is indicated. All vulnerable adult reports will be audited for 2 months for timeliness. 100% auditing will continue as long as compliance is below 100%. The Director of Nursing and/or designee will be responsible for ongoing compliance.	

Electronically delivered
September 10, 2020

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

Re: State Nursing Home Licensing Orders
Event ID: ND3511

Dear Administrator:

The above facility was surveyed on August 25, 2020 through August 28, 2020 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00538	A. BUILDING: _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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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 8/25/20, to 8/28/20, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure. The following complaints were found to be substantiated:	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 H5255071C with licensing order issued at 1980. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
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		9/24/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00538	A. BUILDING: _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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) COMPLETE DATE
21980	Continued From page 2 (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 immediately reported (no later than 2 hours) to the State Agency (SA) for 1 of 3 residents (R3) reviewed for allegations of potential abuse. Findings include: R3's annual Minimum Data Set (MDS) dated 6/30/20, identified R3 was cognitively intact and had diagnoses which included heart failure, Diabetes Mellitus, respiratory failure and anxiety. The MDS indicated R3 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, toileting, bathing, dressing and grooming.	21980	Corrected	

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21980	Continued From page 3 R3's annual care area assessment (CAA) dated 7/13/20, identified R3 had intact cognition and had respiratory failure, heart failure, Diabetes Mellitus and anxiety. The CAA identified R3 required extensive assistance with most ADL's which included bed mobility, toileting, bathing, dressing, grooming and transferred with the use of a mechanical lift. R3's care plan revised 8/17/20, indicated R3 had a potential alteration in cognitive impairment related to cognitive scores that fluctuated. R3's care plan indicated R3 had a history of refusing cares and reporting rough treatment by staff. The care plan instructed staff to provide support as needed, actively involve R3 in her care and allow R3 choices. R3's care plan identified R3 had a self care deficit related to impaired mobility and required extensive assistance with most ADL's which included bathing, dressing, grooming, toileting, and bed mobility. R3's care plan indicated R3 did not walk and required the use of a mechanical lift for transfers. Review of late entry progress note on 3/25/20, at 1:08 p.m. R3 reported to staff she had some care concerns and notifications were completed. A copy of the facility's internal incident report was requested and was not provided. Review of the SA Nursing Home Incident Report (NHIR), revealed the allegation occurred at 3/25/20, at 2:00 a.m. and the allegation was reported to the SA on 3/25/20, at 4:34 p.m., 14 1/2 hours after the allegation had occurred. On 8/26/20, at 11:19 a.m. director of nursing (DON) indicated staff were expected to report all	21980		

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21980	Continued From page 4 allegations of abuse immediately to a manager, DON, licensed social worker (LSW) or the administrator and one of them would file a report to the SA within two hours. DON stated the facility was notified of R3's allegation of abuse sometime on the day shift on 3/25/20, and was not able to provide an exact time. DON reviewed R3's late entry progress note dated 3/25/20, at 1:08 p.m. and confirmed the allegation had not been reported to the SA within the two hour time frame. On 8/26/20, at 11:52 a.m. nursing assistant (NA)-A stated she worked the 6:30 a.m. to 3:00 p.m. shift on 3/25/20, and confirmed when she provided cares to R3 that morning, R3 informed her she had been beat up by staff during the night. NA-A stated she immediately informed the charge nurse working that day of the allegation of abuse. NA-A stated she was aware all allegations of abuse were expected to be reported immediately. NA-A stated she routinely provided cares to R3 between 10:30 a.m. to 11:00 a.m. most mornings. On 8/26/20, at 12:01 p.m. the administrator stated she expected all allegations of abuse were to be reported immediately to LSW or designee and they would file the report to the SA within two hours. The administrator confirmed R3's allegation of abuse was not reported within two hours to the SA. Review of facility policy titled Abuse Prevention Plan undated instructed staff to immediately report the allegation of abuse to the person in charge and to report to the SA within two hours.	21980		

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21980	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review the facility polices in regards to reporting of allegations of mistreatment and/or injuries of unknown origin to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		