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	05/22/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation and interview the facility failed to provide a clean, safe and home-like environment for 3 of 3 residents (R1, R4, R11) reviewed for a clean environment on the 4th floor and [NAME] end. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact and admitted on , d+[DATE]. R1's progress note dated 4/16/24, indicated R1 wanted to move to another facility due to housekeeping and other concerns. On 5/21/24 at 12:38 p.m., during an interview family member (FM)-A stated R1 was concerned the facility was not clean and didn't have sufficient staff to clean. On 5/21/24 at 12:57 p.m., during an interview social worker (SW)-B stated R1 expressed general concerns to her about cleanliness of her room and said her room was dirty. On 5/21/24 at 1:30 p.m., during an interview SW-C stated R1 complained about a dirty tray table and had other isolated complaints about facility cleanliness, and facility maintenance. On 5/21/24 at 4:14 p.m., during an observation the [NAME] end of third floor there was a strong smell of urine near the entrance to the staircase. Both sides of the hallway were lined with equipment including tray tables, a nightstand, wheelchair, wide wooden chair, lamps, garbage bins, a bed with many items piled on it: a television, boots, a cork board, a long window shade, and dirty bedside commode on it. R4's quarterly MDS dated [DATE], indicated R4 was cognitively intact. On 5/21/24 at 4:56 p.m., during on observation and interview R4 stated, If you want to be grossed out, look behind my chair and behind my nightstand. Behind each was food particles, thick dust build up, and debris. R4 stated she hired a friend to clean her bathroom because she wanted it to be usable for her visitors. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 5:35 p.m., during an interview nursing assistant (NA)-E stated he smelled urine at the end of third floor hall and further stated, People say it smells. NA-E also stated the hallway contained too many objects for residents to get by in a wheelchair, and it wasn't safe for residents with all the equipment in the hallway. On 5/21/24 at 5:37 p.m., during an interview registered nurse (RN)-C stated the [NAME] end of third floor smelled of urine and the facility did not have a housekeeper for third floor. On 5/21/24 at 5:33 p.m. during an observation, the stairwell entry to the [NAME] end of third floor had a flat cart with a lift chair and another large sitting chair blocking the way to the stairwell. A sign on the stairwell door indicated, Please do not block fire exit with any equipment. On 5/22/24 at 11:26 a.m., during observations and interview with the director of nursing (DON), upon walking down the [NAME] end of the third floor, the DON acknowledged the area smelled of urine. Upon inspection of the EZ stand (brand of sit to stand mechanical lift) on the East end of the hall, the DON acknowledged the foot stand of the EZ Stand had dirt, crumbs, appeared sticky and stated she would not want residents to use it that way. The DON further stated she did not have a cleaning schedule for the EZ Stands and the flat cart at the [NAME] end of the hallway could prevent egress to the stairwell. On 5/22/24 at 11:29 a.m., during an observation and interview with the DON in R4's room, the DON looked behind the recliner and nightstand and under the bed and stated, It's not clean. R4 stated to the DON she paid a friend to clean in her room and bathroom. R4 further told the DON her room did not smell because her friend cleaned and because she had a room deodorizer, but often the area outside the room smelled because the trash room was right next door. The DON acknowledged R4's toilet had a black ring around the bowl, and R4 should not have to pay privately for cleaning staff. The DON walked out of R4's room and into the trash room which was located next to R4's room. The trash chute was propped open by the trash room door and had a strong foul odor. The DON stated, This isn't supposed to be like this. On 5/22/24 at 1:13 p.m., during an interview, a friend (FR)-A of R4 stated she was hired by R4 to clean R4's personal refrigerator and bathroom. R11's quarterly MDS dated [DATE], indicated R11 was cognitively intact. On 5/22/24 at 1:28 p.m., during an observation and interview R11 stated her windowsill had never been cleaned and could not recall when her floor was last cleaned as it was too long ago. R11's floor had visible dirt and debris. Behind R11's recliner was a napkin with a layer of dust on it and under the bed was visibly dirty and had debris. On 5/22/24 at 1:46 p.m., during an observation and interview R10 stated her room hadn't been cleaned in a week. R10 had a plastic wrapper, a piece of paper, and a wadded-up Kleenex under her bed, and a thick layer of dust on her dresser. R10's closet was missing the doors. R10 stated maintenance staff removed her closet doors a month ago and she would like them back. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 2:13 p.m., during an observation and interview, NA-F was observed mopping the dining area on third floor. The floors in the hallways were visibly dirty. NA-F stated the facility did not have housekeeping staff for third floor. NA-F acknowledged an awareness of all the equipment in the hallway and stated it was unsafe for residents and should be pushed to one side only. NA-F explained residents in wheelchairs could not navigate the hallway independently, and the equipment in the hallway could potentially be in the way to get residents out quickly in an emergency. NA-F acknowledged the floors in the hallway were not clean. On 5/22/24, at 2:26 p.m., during an observation and interview the administrator stated the facility was short of housekeeping staff, and was without a housekeeper on third floor. On 5/22/24, at 2:35 p.m., during an observation and interview with housekeeper (HK)-A and the administrator in R11's room, R11 stated, This room is filthy, and requested to get her closet doors back as they were removed a month prior. The administrator acknowledged R11's room should have closet doors, the windowsills were dirty, and there was debris and dirt on the floor. HK-A stated he knew rooms looked like R11's and acknowledged the housekeeping department was short-staffed and had been for a couple of months. HK-A stated there were four housekeepers who shared the work in two buildings. The housekeeping schedule printed 5/22/24, indicated there were three housekeepers on staff, including the supervisor. The Environmental Services - Cleaning policy dated August 2017, indicated the facility was maintained in a clean and hygienic condition with written schedules for cleaning and decontamination. The policy indicated regular cleaning and maintenance of equipment to ensure particle removal, and high touch areas were cleaned daily including nightstands, toilets, and mobility devices. Further, the policy indicated staff clean surfaces such as window ledges, toilets, floors according to the schedule established by the supervisor.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on interview, observation, and document review the facility failed to ensure baths were given as ordered for 2 of 3 residents (R4, R10) who needed assistance with activities of daily living (ADLs). Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 was cognitively intact, and was fully dependent upon staff to bathe. R4's care plan dated 4/17/24, indicated a self-care deficit for bathing, assistance of one staff for weekly bath dated 10/17/23, and offer a second shower weekly dated 10/17/23. R4's physician orders dated 2/5/24 indicated R4 was to bathe twice weekly on Thursday and Sunday. R4's Point of Care (POC) nursing assistant (NA) bath documentation in the electronic health record (EHR) indicated from 4/1/24 to 5/22/24, R4 missed baths on 4/7/24, 4/18/24, 5/2/24, 5/5/24, 5/16/24, and 5/19/24. R4's record did not identify the reason why these baths were missed. The POC documentation further identified R4 required maximum assistance of staff to bathe. On 5/21/24 at 4:56 p.m., R4 stated she was supposed to have two showers weekly due to a history of urinary tract infections but did not get two showers weekly. On 5/21/24 at 5:35 p.m., during an interview NA-E indicated sometimes there was only one NA to care for 30 residents until a replacement could be found. If residents have showers, we can't get to them, and they go without a shower. NA-E stated, when she worked the week of 5/12/24 to 5/18/24, the facility had one NA working on third floor. R10's quarterly MDS dated [DATE], indicated R10 was cognitively intact and required supervision for a shower or bath. R10's physician orders dated 3/26/24, indicated R10 had a weekly bath on Thursdays, make sure shower/bath is completed, and notify nurse manager if R10 refuses. R10's care plan dated 1/15/24, indicated shower weekly, and assist of one staff to shower. R10's progress notes indicated from 3/22/24 to 5/22/24, R10 missed baths on 4/18/24, 4/25/24, 5/2/24, and 5/16/24. On 5/22/24 at 1:46 p.m., during an observation and interview R10 had greasy uncombed hair. She stated she needed set-up assistance for a shower, but staff did not have time to help her. Further R10 stated staff tell her there is not enough staff for baths, or have higher priority residents, and, It makes me feel like they don't care about me. They are getting their money without doing anything. I am unimportant. I am not respected as a person. R10 stated she last had a shower about 2-3 weeks ago, which was also when she last had a bed linen change. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 2:13 p.m., during an observation and interview, NA-F stated the facility, Occasionally, had enough staff to assist residents with showers. On 5/22/24 at 4:32 the director of nursing (DON) stated the bath data provided was all the recorded baths and staff had time to perform baths. The DON was not aware baths were not being done. The Staffing and Daily Work Assignments policy dated February 2019 indicated sufficient numbers of staff with the skill and competency necessary to provide care and services for all residents in accordance with care plans were provided to residents. The Activities of Daily Living policy dated June 2021 indicated care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene, including bathing. Further, the policy indicated the resident's response to interventions will be documented, monitored, and revised as appropriate.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on interview and document review the facility failed to ensure medications were appropriately transcribed into the electronic health record (EHR), ordered timely and correct medication dosages were administered in accordance with physician orders for 1 of 1 residents (R3), reviewed for missed medication errors. Findings include: R3's face sheet printed 5/22/24, indicated R3 admitted to the facility with diagnoses of enterocolitis due to clostridium difficile, cirrhosis of the liver, acute gastric ulcer with hemorrhage, ascites, and reflux disease. R3's admission Minimum Data Set (MDS) dated [DATE], was not complete as R3 was in the facility less than 24 hours. R3's medication orders dated 5/2/23, were as follows: -cholestyramine-aspartame powder in packet (medication to lower cholesterol), 4 grams by mouth with meals twice daily at 8:00 a.m., and 4:00 p.m. (start date 5/2/24). -pantoprazole tablet delayed release (medication for gatroesophageal reflux (heart burn)) 40 milligrams (mg) twice daily by mouth at 8:00 a.m., and 4:00 p.m. (start date 5/2/24). -linezolid tablet (antibiotic), 600 mg by mouth every 12 hours at 8:00 a.m. and p.m. (start date 5/2/24). -Vancomycin (antibiotic) capsule 125 mg by mouth four times a day at 8:00 a.m., 12:00 p.m., 8:00 p.m., and 12:00 a.m. (start date 5/2/24). R3's medication administration record (MAR) identified the aforementioned physician orders , however the orders in the MAR did not match the provider orders. The MAR lacked the 12:00 a.m. dose of Vancomycin, the 4:00 p.m. dose of pantoprazole, and the 4:00 p.m. dose of cholestyramine. Further the MAR indicated the 8:00 p.m. and 12:00 a.m. doses of Vancomycin and the 8:00 p.m. dose of linezolid were not administered. R3's progress notes had not identified R3's physician was notified of missed medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 12:51 p.m., during an interview the pharmacist (PH)-A stated the pharmacy received the facility's medication request for R3 on 5/2/24 at 3:42 p.m. prior to admission. The pharmacy could not fill the medication order until the pharmacist saw the admission confirmation, which occurred on 5/2/24 at 5:14 p.m The PH-A stated the pharmacy started to process the medication order at 6:01 p.m., and the medications were sent on the overnight delivery on 5/3/24 around 3:00 a.m. The PH-A stated pantoprazole was available in the facility automated dispensing unit (ADU - used for emergency medication supply). Staff requested to use it, it was pulled from the ADU, but there was no record it was administered. The PH-A stated even though the Vancomycin dose was available in the ADU, staff did not request to use it. Additionally the PH-A stated facility staff should have notified the provider of the missed doses. The PH-A further stated the facility could have called to request immediate delivery but had not The automated dispensing unit ADU list printed 5/22/24, indicated pantoprazole 20 mg tablets and Vancomycin 125 mg capsules were available for use. On 5/22/24 at 12:47 p.m., during an interview registered nurse (RN)-B stated staff should have informed the provider if the medications were not administered, and acknowledged there was no evidence a provider was contacted. On 5/22/24 at 10:40 a.m., during an interview the director of nursing (DON) stated the process to get medications for newly admitted residents was the health unit coordinator (HUC) entered the initial medication orders in the electronic health record (EHR), then a nurse checked the orders and faxed the orders to the pharmacy. The DON stated, My understanding is we can get medications quickly. I don't know where the process broke down. The DON further stated she was not sure why the orders were incorrect in the MAR when two staff reviewed them. DON acknowledged R3's MAR indicated only once daily dosing for pantoprazole and cholestyramine powder when the orders indicated twice daily for each and Vancomycin was indicated on the MAR three times daily, but the orders indicated four times daily. The DON acknowledged R3 did not receive linezolid, Vancomycin, pantoprazole, and cholestyramine on 5/2/24, as ordered, and did not know why staff did not use the ADU supply for pantoprazole and Vancomycin. On 5/22/24 at 12:33 p.m., during an interview the pharmacy consultant (PC) stated the pharmacy must get the medications to the facility within four hours per the contract. The PC stated the missed doses did not have a negative impact on the resident but the facility should report missed doses to the provider. The Administering Medications policy dated 2020, indicated medications were administered as indicated and ordered by the provider, within their prescribed time, and with any irregularities, appropriate notifications would be completed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation, interview, and document review the facility failed to serve food at a palatable temperature to 4 of 4 residents (R4, R9, R11, R10) reviewed for dietary and nutrition. Findings include: On 5/21/24 at 12:57 p.m., during an interview social worker (SW)-B stated residents expressed the food was cold, and it remained a, Prevalent concern. On 5/21/24 at 1:30 p.m., during an interview SW-C stated, Cold food is a big complaint, and had been for years. R4's quarterly minimum data set (MDS) dated [DATE], indicated R4 was cognitively intact. On 5/21/24 at 4:56 p.m., during an interview R4 stated the hot food was usually served cold. On 5/22/24 at 8:50 a.m., during an observation and interview the director of culinary services (DCS) performed temperature checks on R9's food prior to staff serving the food to R9. The meal came in a hot box (cart designed to hold food trays at an appropriate temperature before service) from the building next door, and sat on a cart to be distributed to the resident rooms for about five minutes. The DCS stated this was the procedure until he can get steam tables. Review of the temperature logs from the kitchen indicated the food was at the appropriate temperatures when it left the kitchen. The oatmeal temperature 100 degrees Fahrenheit (F), the scrambled eggs were 82 degrees F, and the potatoes were 72 degrees F. The DCS stated the food temperatures were not at a palatable temperature. The DCS stated he was aware residents complained about food temperatures, and for nine months had been working on a plan to buy steam tables and hire twleve additional kitchen staff R9's food was served at 8:55 a.m., without reheating the food to a palatable temperature. The DCS stated, It has been less than four hours; it is okay to serve. The temperature logs from the kitchen indicated the food was served within an hour of leaving the kitchen. R9's significant change MDS dated [DATE], indicated R9 was cognitively intact. On 5/22/24 at 8:56 a.m., during an interview R9 stated he expected his breakfast around 8 a.m., the meal was about an hour late and, the food was Very cold. On 5/22/24 at 10:40 a.m., the director of nursing (DON) stated food should be at the correct and palatable temperature when it is served, staff should reheat the food if it is not. DON indicated residents could get sick from serving food that was not at a safe temperature. The DON reviewed the breakfast food temperatures noted by the DCS at 8:50 a.m., and stated the foods served at those temperatures would not be palatable. On 5/22/24 at approximately 12:10 p.m., during an observation and interview the DCS performed temperature checks on the food for R10 and R11. R10's turkey and gravy was 97.7 degrees F and potatoes were 98 degrees F. R11's hot dog was 115 degrees F. The DCS stated, I would expect staff to reheat it if the resident preferred. There are microwaves on every floor. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's quarterly MDS dated [DATE], indicated R11 was cognitively intact. On 5/22/24 at 1:28 p.m., during an interview R11 stated she didn't eat her lunch because, It was on the cold side. I had them take it back. It didn't look right so I didn't eat it. Practically every day the food is cold. R11 stated she usually has to ask to have her food warmed. R10's quarterly MDS dated [DATE], indicated R10 was cognitively intact. On 5/22/24 at 1:46 p.m., during an interview R10 stated, Lunch was cold, as usual. The food is always cold. They know. They don't heat it up. The Maintaining Proper Food Temp During Food Service policy dated 2012, indicated food served will be maintained at proper hot and cold temperatures prior to and during meal service to assure food quality and tastiness/ palatability as well as food safety. The policy indicated hot food would be served at a temp of 135 degrees Fahrenheit (F) during tray assembly.