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	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Care Center on Humboldt	512 Humboldt Avenue Saint Paul, MN 55107

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review, the facility failed to notify family and physician regarding a resident change in condition for one of one resident (R1) reviewed when R1's venous ulcer wound worsened requiring hospitalization . Findings include: R1's medical record indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of venous insufficiency. R1's additional diagnoses included non-pressure chronic ulcer of other part of right lower leg with fat layer exposed on right shin, methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere- wound culture, pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere-wound culture, chronic kidney disease stage 3, pressure ulcer of right heel (unstageable), pressure ulcer of sacral region (unspecified stage), morbid obesity due to excess calories, non-pressure chronic ulcer of other part of right foot with unspecified severity on right toe, non-pressure chronic ulcer of right heel and midfoot with unspecified severity on lymphademic wound on right foot, chronic venous hypertension with ulcer of right lower extremity on right shin, non-pressure chronic ulcer of right calf with fat layer exposed, non-pressure chronic ulcer of left calf with fat layer exposed, nicotine dependence, reduced mobility, weakness, peripheral vascular disease, unspecified open wound on lower leg, cellulitis of right lower limb, and cellulitis of left lower limb. R1's minimum data set (MDS) dated [DATE] indicated R1 had four venous and arterial ulcers present at the time of the assessment. The MDS indicated R1 had one of those venous and arterial ulcers that was unstageable due to coverage of wound bed by slough and/or eschar. The MDS indicated R1 had one unstageable venous or arterial ulcers present upon admission. R1 had a pressure reducing device for chair, pressure reducing device for bed, nutrition or hydration interventions, pressure ulcer/injury care, application of ointments and medications, application of nonsurgical dressings, and application of dressings to feet. R1's progress note dated 6/5/24 indicated R1 did not want to see the in-house wound care provider but would rather see an outside agency for wound cares. R1's skin risk observation assessments dated 3/13/24 to 7/29/24 indicated the facility were assessing, monitoring, and following R1's care plan for venous and atrial ulcers and reducing the risk of pressure ulcers. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's wound documentation dated 3/14/24 to 7/24/24 indicated wound monitoring with wound measurements and description. R1's treatment administration record (TAR) dated 8/1/24 through 8/19/24 indicated staff was to cleanse R1's right lower extremities and left lower extremities with vashe, pat dry, apply triad around the wound, start santyl and calcium alginate to open areas, and cover with dressing. This wound treatment was to be done daily or twice daily if the wounds are leaking through the dressings. This wound treatment was completed daily from 8/1/24 through 8/19/24. R1's weekly skin check assessment dated [DATE] indicated R1 had a pressure ulcer/injury and a vascular ulcer. The assessment indicated R1 had identified pressure ulcers and vascular ulcers located on the front of the right lower leg, front of left lower leg, back of left lower leg, right heel, and another unspecified location. The assessment referred to the outside clinic description for location of R1's front right lower leg. R1's care plan dated 8/6/24 indicated R1 was at risk for alterations of skin status related to venous ulcers on right lower extremities and left lower extremities and pressure ulcer on the right heel. The care planned goals were to not develop any skin alterations. Interventions included turning and positioning program due to decreased mobility with assist of two, R1 preferred to be repositioned every two to three hours, R1 had a special mattress, heel protectors with offloading in bed, barrier cream applied to dry areas as needed, and wheelchair cushion. The care plan indicated staff would refer to the treatment administration record (TAR) for current wound treatments. R1's facility wound documentation dated 8/8/24 indicated R1's wound on right shin measured fourteen point five centimeters in length, thirteen centimeters wide, and zero point two centimeters deep. The wound had moderate serous exudate that was foul. The wound's depth of tissue injury was full thickness through the dermis and down to the subcutaneous tissue and muscle. The wound's tissue type was slough. There was no identification of a tendon. R1's progress note dated 8/8/24 indicated R1's 8/5/24 outside wound care appointment was missed because of a transportation issue, R1 rescheduled the appointment for 8/8/24. When R1 arrived for the appointment on 8/8/24 the clinic told her the appointment was for 8/5/24 and they could not see her. The clinic rescheduled the wound care appointment 8/19/24. The facility called the outside wound care clinic to see if R1 could be seen weekly, sooner than 8/19/24, and the outside wound care provider staff stated that could not be done due to low staffing. R1's progress note dated 8/9/24 indicated R1 was moved from the 4th floor transitional care unit (TCU) to the 3rd floor long-term care (LTC) unit. R1's progress note dated 8/10/24 indicated registered nurse (RN)-A debrided and cleaned the necrotic tissue wound the wound with Vashe and removed the purulent discharge. RN-A noted two to three centimeters (cm) of the peroneal tendon on the right foot was exposed, the surrounding tissue was moist and had purulent and serosanguinous discharge. RN-A applied Santyl and Calcium Alginate and then covered with dressing. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's MDS dated [DATE] indicated R1 had four venous and arterial ulcers present at the time of the assessment. The MDS indicated R1 had one of those venous and arterial ulcers that was unstageable due to coverage of wound bed by slough and/or eschar. The MDS indicated R1 had one unstageable venous or arterial ulcers present upon admission. MDS indicated R1 had a pressure reducing device for chair, pressure reducing device for bed, nutrition or hydration interventions, pressure ulcer/injury care, and application of ointments and medications. R1's brief interview for mental status (BIMS) assessment dated [DATE] indicated R1 had a score of fourteen, which indicated R1 was cognitively intact. R1's provider progress noted dated 8/13/24 indicated the provider saw R1 at the facility. R1 now resided in the LTC unit. Denied wound pain, was followed by vascular/podiatry. R1 had a wound vac and the provider was not able to see the wounds as the wound vac and dressing changes were scheduled on Monday, Wednesdays, and Fridays. Serous drainage was visible. R1's progress note dated 8/17/24 indicated RN-A debrided and clean the necrotic tissue around the wound with Vashe and removed the purulent discharge. RN-A noted serosanguinous discharge and applied Santyl, Calcium Alginate, and covered with a dressing. A tendon being exposed was not noted. R1's progress note dated 8/18/24 indicated RN-A debrided the necrotic tissue around the wound with Vashe and removed purulent discharge. RN-A noted serosanguinous was present and applied Santyl and Calcium Alginate and applied a dressing. A tendon being exposed was not noted. R1's progress note dated 8/19/24 indicated RN-C received a call from R1's outside wound clinic stating R1 had been transferred to the hospital due to the tendon exposure on R1's right leg. During an interview with family member (FM)-A on 8/27/24 at 10:28 a.m., FM-A stated he was not notified on the progression of the wounds, but he was notified that R1 was going to the doctor appointments. FM-A stated he was not notified that part of R1's tendon was showing prior to leaving for her doctor's appointment on 8/19/24. During an interview with RN-A on 8/27/24 at 11:02 a.m., RN-A stated R1 was transferred to the 3rd floor long-term care (LTC) from the transitional care unit (TCU) on the 4th floor on 9/9/24. RN-A stated he did not receive report from the TCU nurse regarding R1 or her wounds. RN-A stated R1 had her wounds cleaned daily and new dressings applied daily. RN-A stated R1 had a wound vacuum-assisted closure (VAC) (A wound VAC is a treatment with a dressing, tubing, and a suction pump to remove excess fluid and dead tissue from a wound to help heal the wounds.) placed three times a week. RN-A stated he first saw the tendon exposure on R1's right shin on 8/10/24. RN-A stated he was unsure whether the tendon was exposed prior to 8/10/24 because he did not receive report about R1's wounds when she was transferred to the LTC floor. RN-A stated that on 8/10/24 he cleaned the wounds on R1's right shin but did not notify anyone of the tendon exposure. RN-A stated on 8/12/24 he notified the clinical manager (CM) that the tendon was exposed when he changed the dressing on 8/10/24. RN-A stated a change in condition when it came to wounds would be if the resident had an infection but did not mention if a tendon was exposed. RN-A stated when he wrote the progress note on 8/18/24 he noted the tendon was exposed on her right shin but did not notify the family or provider. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 11:21 a.m., licensed practical nurse (LPN)-A stated he worked with R1 on the TCU. LPN-A stated he would change R1's wound dressings and noted he did not see any tendon showing on her right shin. During an interview on 8/27/24 at 12:39 p.m., the CM stated she had been transferred to the LTC unit for about a week prior to her going to the hospital. CM stated she remembers seeing R1's wound on her right shin and that her tendon was showing. CM stated she did not notify anyone that R1's tendon was showing on her right shin because she had thought R1 was already seen for the wound, the appropriate people were notified, and the LTC unit was completing the treatments as prescribed. CM stated she did not have a baseline on R1's wounds because she did not receive a report when she was transferred to the LTC unit from the TCU. CM stated she did not look at any progress notes or previous wound reports when she was transferred to the LTC unit. CM stated the facility got R1 in to see her outside wound care provider within 2 days of them seeing the tendon for the first time. During an interview on 8/27/24 at 1:37 p.m., RN-C stated she worked with R1 the morning of 8/19/24. RN-C stated she saw R1's tendon exposed on her right shin when she was performing her wound cares. RN-C stated the first time she saw R1's tendon being exposed was on 8/14/24 when she helped RN-A with wound cares. RN-C stated at the time, she did not notify anyone of R1's tendon exposure because she did not know R1's baseline. RN-C stated on an unknown date, she had a hard time with R1's wound VAC, so she had to call the CM and the CM could not figure out the wound VAC, so she had to call the director of nursing (DON). During an interview on 8/27/24 at 2:00 p.m., the clinical assistant (CA) stated R1 came to the wound care clinic on 8/19/24 where the provider had noted the tendon exposure on R1's right shin. The CA stated the wound care clinic was not notified on or around 8/10/24 that R1's tendon was being exposed. During an interview on 8/27/24 at 2:20 p.m., the interim director of nursing (IDON) stated the director of nursing (DON) was currently on a leave of absence that started 8/20/24. IDON stated she did not know if the DON knew about the tendon being exposed prior to 8/19/24. During an interview on 8/27/24 at 2:47 p.m., the medical director (MD) stated he did not recall if he was notified of R1's change in condition or not, but he stated if he was notified, it would be through email, and he did not recall seeing any emails about the change in condition. An attempt was made to interview the DON at 8/27/24 at 3:09 p.m. and 3:27 p.m. but was not successful. An attempt was made to interview the provider nurse practitioner (NP) on 8/27/24 at 5:00 p.m. but was not successful. The facility provided a change in condition policy and procedure that was undated. The policy and procedure stated the attending provider was to be notified of the change in condition and implement orders for treatment and appropriate monitoring as directed. The policy and procedure stated the facility staff would notify the resident and/or representative of the change in condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on observations, interviews, and record review the facility failed to reduce the risk of harm for one of one resident (R2) reviewed accidents and hazards. R2 required the use of an EZ Stand and facility staff were using a large sized harness. The EZ Stand manufacturer guidelines state a large harness fit a person between one hundred ninety pounds to three hundred twenty pounds. R2 exceeded the weight limit. Findings include: The facility provided the EZ Way Smart Stand operator's instructions that stated a large sling was to be used on a resident between forty to fifty-six inches in circumference around the resident's torso and weighed between one hundred ninety to three hundred twenty pounds. During an observation on 8/26/24 at 9:20 a.m., there was a EZ Stand outside R2's door with a large harness on the back of it. The EZ Stand stated it had a four-hundred-pound capacity. During an observation on 8/26/24 at 9:34 a.m., the occupational therapy assistant (OTA) was getting R2 up from her wheelchair for a therapy session. The OTA applied the large sling and R2 stated Oh that is the medium harness and the OTA stated, This is the large sling and that is the sling that we wanted. The OTA attached the harness that was around R2 to the EZ Stand, R2 was lifted, and was moved to her wheelchair. During an observation on 8/26/24 at 1:40 p.m., nursing assistant (NA)-A attached the large harness around R2 and attached the harness to the EZ Stand. NA-A assisted R2 with incontinent cares and then lowered R2 back to her recliner. During an observation on 8/26/24 at 2:23 p.m., NA-A applied the large harness around R2 and attached the harness to the EZ Stand. NA-A lifted R2 up with the EZ Stand and then registered nurse (RN)-B was looking at a spot on R2's body. NA-A lowered R2 back to her recliner and then removed the harness. R2's medical records indicated R2 was admitted to the facility on [DATE] with a primary diagnosis of multiple sclerosis. R2's additional diagnoses included dizziness and giddiness, morbid obesity due to excess calories, legal blindness, reduced mobility, meralgia parasthetica of the left lower limb, lymphedema, macular degeneration, muscled weakness, and abnormalities of gait and mobility. R2's care plan stated R2 used a EZ Stand to assist in her activities of daily living (ADL's). The care plan did not indicate what size harness facility staff should be using on R2. R2's brief interview for mental status (BIMS) dated 7/12/24 indicated R2 had a BIMS score of 15, which indicated R2 was cognitively intact. R2's clinical documentation assessment dated [DATE] indicated R2 required total dependence from staff for transfers. The assessment indicated R2 required the use of a EZ Stand. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's fall risk and functional limitations assessment dated [DATE] indicated R2 required the use of a EZ Stand for transfers. R2's functional abilities assessment indicated R2 required total dependence from staff for all transfer needs. R2's weight documentation dated 7/1/24 indicated R2's weight was three-hundred ninety-four pounds and three ounces. During an interview on 8/26/24 at 10:55 a.m., R2 stated she recently went to the bariatric clinic about a month ago and she weighed four hundred and nine pounds. During an interview on 8/26/24 at 1:30 p.m., NA-A stated she used a large harness on R2 because that is the only size the facility had for R2. NA-A stated the large harness can hold up to three hundred and twenty-five pounds. NA-A could not recall how many pounds R2 weighed. NA-A stated the large harness is the right size for R2. During an interview on 8/26/24 at 2:00 p.m., the OTA stated she used the large harness on R2. OTA stated she determined the use of the large harness just by looking at R2. During an interview on 8/26/24 at 2:15 p.m., NA-B stated there are residents who use extra-large harnesses on different floors. During an interview on 8/26/24 at 2:25 p.m., RN-B stated harness sizes correspond with the resident's weight. RN-B stated she could not recall what size harness R2 used or how much R2 weighed. RN-B stated nurses are responsible for determining harness sizes for residents. During an interview on 8/26/24 at 3:38 p.m., clinical manager (CM) stated she would expect a harness to fit the resident well with it not being too tight or too loose. CM stated the health information manager (HIM) assessed residents for their harness sizes. CCM stated she was responsible for determining a resident's harness size. CM stated she did not do an assessment for R2's harness size. CM stated the HIM likely assessed R2 for her harness size because she had not since she started working at the facility four months ago. CM stated she does not usually go by weight when determining a resident's harness size. During an interview on 8/26/24 at 4:21 p.m., HIM stated the CM is responsible for assessing resident's size harness. HIM stated the CM will assess the resident, the CM would tell HIM what size harness the resident is, the HIM would keep record of size harnesses for residents, and she would order harnesses if needed. HIM stated the facility has medium, large, extra-large, and two-extra-large harnesses in the building. HIM stated she is not sure what size harness R2 uses because she was assessed prior to her starting in March 2024. During an interview on 8/27/24 at 2:20 p.m., the interim director of nursing (IDON) stated the nursing staff would be responsible for determining a resident's harness size. IDON stated harness sizes are based on a resident's weight. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facilities Safe Patient/Resident Handling and Movement Policy policy and procedure was undated. The policy and procedure stated the facility administer was responsible for furnishing sufficient lifting equipment/aides to allow staff to use them when needed for safe patient handling and movement and to seek input from care and support staff on equipment selection process. The policy and procedure stated supervisors will ensure that mechanical lifting devices and other equipment/aides are accessible to staff. The policy and procedure stated supervisors would ensure that all residents are assessed upon admission, re-admission, significant changes in status, and quarterly for risks related to patient handling tasks, to ensure high-risk patient handling tasks are assessed prior to completion and are completed safely, using mechanical lifting devices and other approved patient handling aides and appropriate technique, and to ensure mechanical lifting devices and other equipment/aides are available. The policy and procedure stated the patient assessment criteria will assist supervising health care staff in considering critical patient characteristics that affect decisions for selecting the safest equipment and techniques for patient handling and movement tasks. The policy and procedure indicated a key assessment criterion is the patient's height and weight.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on observations, interviews, and record review, the facility failed to follow resident meal tickets , provide palatable meals, and provide meals to meet the needs of the residents for four of four residents (R2, R4, R5, R6) reviewed for meals and food . R2 requested a butterscotch square and French bread for lunch but received chocolate cake and no bread. R4, R5, and R6 were not able to finish their lunch due to the food either being too dry or could not eat the lunch due to not having teeth. Findings include: During an observation on 8/26/24 at 12:08 p.m., R4 had a hard time cutting up his pork chop. R4 was putting pressure on his fork and knife while attempting to cut his pork chop. During an observation on 8/26/24 at 12:20 p.m., R4 wheeled out of the dining room in his wheelchair. On his plate was a pork chop and some carrots. During an observation on 8/26/24 at 12:09 p.m., R5 had a hard time cutting up her pork chop. R5 was putting pressure on her fork and knife while attempting to cut her pork chop. During an observation on 8/26/24 at 12:15 p.m., R5 sat back in her wheelchair and the aide asked if she was done with her lunch and R5 stated she was done with her lunch and the aide took her meal tray away from the table. On R5's lunch place was seventy-five percent of her pork chop. During an observation on 8/26/24 at 12:10 p.m., R6 was seen eating a baked potato and carrots for lunch. R6 did not eat her pork chop. During an observation on 8/26/24 at 12:17 p.m., R2 received a French onion pork chop, honey glazed baby carrots, rice, and chocolate cake. During an observation on 8/26/24 at 12:25 p.m., R6 sat back in her wheelchair and stated she was done with her lunch and an aide took her meal tray away from the table. On her plate was a full pork chops and seventy-five percent of her carrots. During an observation on 8/26/24 at 12:37 p.m., the surveyor received a resident lunch plate including steamed carrots, rice, and a pork chop smothered in gravy. The surveyor observed the carrots were cold, the rice was bland and soft, and the pork chop was cold and dry. During an observation on 8/27/24 at 11:59 p.m., one of the facility staff members asked if residents were going to get their cranberry sauce with their meal and one of the kitchen staff members stated they did not have cranberry sauce today. (continued on next page)

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	R2's medical records indicated R2 was admitted to the facility on [DATE] with a primary diagnosis of non-pressure chronic ulcer of right lower leg with fat layer exposed. R2's additional diagnoses included morbid obesity, chronic kidney disease, vitamin B12 deficiency anemia, other mixed anxiety disorders, and reduced mobility. R2's brief interview for mental status (BIMS) assessment dated [DATE] indicated R2 had a score of fifteen, which indicated R2 was cognitively intact. R4's medical records indicated R4 was admitted to the facility on [DATE] with a primary diagnosis of supraventricular tachycardia. R4's additional diagnoses included type two diabetes with diabetic chronic kidney disease, moderate protein-calorie malnutrition, morbid obesity due to excess calories, and mild cognitive impairment. R4's BIMS assessment dated [DATE] indicated R4 had a score of fifteen, which indicated R4 was cognitively intact. R5's medical records indicated R5 was admitted to the facility on [DATE] with a primary diagnosis of hepatic encephalopathy. R5's additional diagnoses included cirrhosis of liver, type two diabetes mellitus with hyperglycemia, and iron deficiency anemia. R5's BIMS assessment dated [DATE] indicated R5 had a score of fifteen, which indicated R5 was cognitively intact. R6's medical records indicated R6 was admitted to the facility on [DATE] with a primary diagnosis of chronic respiratory failure with hypoxia. R6's additional diagnoses included iron deficiency anemia secondary to blood loss, morbid obesity, venous insufficiency, and chronic obstructive pulmonary disease. R6's BIMS assessment dated [DATE] indicated R6 had a score of fifteen, which indicated R6 was cognitively intact. The facility provided a blank meal ticket for 8/26/24 for lunch. The condiment option had margarine. The entree was a choice of French onion pork chop, chef salad bowel, cold cut sandwich, or a chicken caesar salad with dressing. The starch options were herbed rice, baked potato, or macaroni and cheese. The vegetable option was honey glazed baby carrots. The bread option was French bread. The Dessert option was a butterscotch square, vanilla yogurt, strawberry yogurt, or an assorted gelatin cup. The beverage options were hot chocolate, coffee, cranberry juice, grape juice, chocolate milk, hot tea, orange juice, apple juice, or two percent milk. The facility provided a resident menu for 8/26/24 for lunch consisting of French onion pork chop, herbed rice, honey glazed baby carrots, French bread, and a butterscotch square. The facility provided serving temperature logs for 8/26/24 for lunch. The entree serving temperature was one hundred forty-eight degrees, the starch was one hundred sixty-eight degrees. The vegetable was one hundred seventy-three degrees. (continued on next page)

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	The facility provided a blank meal ticket for 8/27/24 for lunch. The condiments were either cranberry sauce or margarine. The entree was either a herb roasted turkey, cold cut sandwich, chef salad bowl, or a chicken caesar salad with dressing. The start options were either sage bread dressing, macaroni and cheese, or a baked potato. The vegetable option was green beans with bacon. The dessert option was either a frosted pumpkin cake, strawberry yogurt, vanilla yogurt, or an assorted gelatin cup. The beverages options were hot chocolate, coffee, cranberry juice, grape juice, chocolate milk, hot tea, orange juice, apple juice, or two percent milk. The facility provided a resident menu for 8/27/24 for lunch consisting of herb roasted turkey, safe bread dressing, green beans with bacon, and a frosted pumpkin cake. The facility provided serving temperature logs for 8/27/24 for lunch. The entree was one hundred eighty-five degrees. The starch was one hundred sixty-two degrees. The vegetable was one hundred seventy-eight degrees. During an interview on 8/26/24 at 10:55 a.m., R2 stated every time she gets a meal, the food is always cold and most of the time the food is overcooked. During an interview on 8/26/24 at 12:11 p.m., R5 stated her lunch was dry and her pork chop was hard to cut. R5 stated her pork chop was hard to eat because there was too much pepper on it. During an interview on 8/26/24 at 12:12 p.m., R4 stated he was not able to eat his pork chop at lunch because it was too dry and hard to eat. R4 stated he was able to eat his rice, carrots, and chocolate cake. During an interview on 8/26/24 at 12:13 p.m., R6 stated her carrots were cold and stated today was the first day her plate was warm. R6 stated in July 2024 she had her dentures on a napkin by her meal tray and the kitchen staff accidently threw out her dentures. R6 stated she has not had her dentures in a little over a month, but she has seen the dentist for replacements. R6 stated she was not able to eat her pork chop at lunch because she only has her top teeth. R6 stated the kitchen staff, or the nursing assistants did not offer her an alternative food option. During an interview on 8/26/24 at 12:17 p.m., R2 stated her carrots and pork chop were both cold from lunch. R2 stated she was really looking forward to the butterscotch bars and was disappointed to receive the chocolate cake. During an interview on 8/26/24 at 1:30 p.m., nursing assistant (NA)-A stated about five years ago, the facility had a kitchen in the building, but now the kitchen staff had to travel from the kitchen which is in another building, put the food on steam tables, and then serve the residents. NA-A she had received many complaints from residents about the food and the food being cold. NA-A stated residents fill out the meal tickets weekly and residents would get upset because they could not change their meal choices. NA-A stated if she saw a resident not eating, the kitchen will sometimes offer alternatives to the meal, or the staff would have to tell the resident that the kitchen staff cannot change their meal. (continued on next page)

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	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Care Center on Humboldt	512 Humboldt Avenue Saint Paul, MN 55107

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 8/26/24 at 2:15 p.m., NA-B stated the residents would fill out their meal tickets weekly. NA-B stated if a resident does not like a meal, he would tell the kitchen staff the resident does not like the food and most of the time the kitchen staff would give them something else to eat. NA-B stated he was unsure what alternatives the kitchen staff would offer residents who do not like or cannot eat the meal. During an interview on 8/26/24 at 3:38 p.m., the clinical manager (CM) stated if a resident did not like the food that was being served, the residents had the option of a chicken salad sandwich, egg salad sandwich, tuna fish sandwich, peanut butter and jelly sandwich, or a variety of soups. The CM stated the kitchen staff did not offer alternative hot meals. During an interview on 8/27/24 at 10:49 a.m., R6 stated a lot of her meals are being served cold even though the kitchen has steam tables. R6 stated they never offer her alternatives if she cannot eat something provided in her meal but states that they will sometimes offer her a tuna fish sandwich or an egg salad sandwich, but stated she does not want a sandwich, she wanted something hot. During an interview on 8/27/24 at 12:10 p.m., dietary aide (DA)-B stated he was not sure how the meal tickets were done and processed. DA-B stated the kitchen would have two options available for residents. DA-B stated if a resident did not want their cold meal, the kitchen could offer them the hot food, and if the resident did not like the hot meal choice, the kitchen staff could offer them cold menu options such as a cobb salad, [NAME] salad, or cold cut sandwiches. DA-B stated the kitchen was supposed to have cranberry sauce at the meal but stated the cooks did not cook it. DA-B stated the kitchen cannot make an item if the item was out of stock. During an interview on 8/27/24 at 2:20 p.m., the interim director of nursing (IDON) stated she would expect the menus offer choices to residents. The IDON stated she would expect the meal tickets and the menus to match. During an interview on 8/27/24 at 3:10 p.m., the administrator stated she would expect the menus and the resident meal tickets to match. The administrator stated she would expect alternatives to be offered to residents who did not like the meal or could not eat the meal. The facilities Menu Standards policy and procedure that was undated. The policy and procedure stated menus were to be followed as written. The policy and procedure stated when changes or substitutions in the menus are necessary, the substitutions much provide equal nutritive value.

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	08/27/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on observation, interview, and record review, the facility failed to ensure an EZ Stand was maintained in accordance with manufacturer guidelines for one of one resident (R2) reviewed for EZ Stands. It is unknown when R2's EZ Stand was last maintained due to no record of it being maintained. Findings include: The facility provided an operator's instructions for EZ Stand with the serial number 907725. The operator's instructions states the manufacturer suggests that components and operating points be scheduled for inspection at intervals not greater than six months. R2's medical records indicated R2 was admitted to the facility on [DATE] with a primary diagnosis of multiple sclerosis. R2's additional dizziness and daffiness, morbid obesity, and muscle weakness. During an observation on 8/26/24 at 9:20 a.m., there is a EZ Stand outside R2's room that had a sticker stating the next maintenance check was due in May 2024. The EZ Stand is called an EZ Way Smart Stand. The EZ Stand's serial number was 907725. The facility provided a Safety Program Checklist for and EZ Way EZ Stand for serial number 907725. On the checklist N/A is marked on the bottom and none of the checklist was marked off for completion. During an interview on 8/27/24 at 9:13 a.m., the environmental services director (ESD) stated the maintenance department had just started maintaining the EZ Stands every other month since June. The ESD stated the facility has the EZ Stand company come out yearly for inspections and maintenance. ESD stated he had maintained all the EZ Stands in July and planned the next maintenance date to be in September. During an interview on 8/27/24 at 11:49 a.m., the ESD stated the EZ Stand with the serial number 907725 was probably maintained before the ESD started with the facility because he did not find any records of it being maintained. During an interview on 8/27/24 at 11:49 a.m., the ESD stated one of the other facility maintenance members stated he could not the EZ Stand with serial number 990725, so the ESD told other maintenance members to write N/A on the maintenance sheet. The ESD stated he never followed up on finding the EZ Stand with the serial number 907725. During an interview on 8/27/24 at 3:10 p.m., the administrator stated she would expect maintenance of the EZ Stands to be done per manufacturer guidelines. The facility's Safe Patient/Resident Handling and Movement Policy policy and procedure was undated. The policy and procedure stated maintenance shall maintain mechanical lift devices in according to manufacturers' recommendations. The policy and procedure stated supervisors shall ensure that mechanical lift devices and other equipment/aides are maintained regularly and kept in proper working order.