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	05/15/2025

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 0689 Level of Harm - 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** 49338 Based on observation, interview, and document review, the facility failed to ensure a resident received adequate supervision and assistance to prevent accidents for 1 of 3 residents (R4) reviewed for falls. This resulted in actual harm when R4 fell and suffered a femur fracture. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance. Findings include: R4's face sheet dated 5/16/25, identified diagnoses of Parkinson's disease (a disease of the central nervous system that affects movement), depression (persistent sadness), and anxiety (a common human emotion involving feelings of worry, nervousness, or unease). R4's Physical Therapy (PT) evaluation dated 4/22/25, identified that R4 was admitted the facility due to weakness and without further PT she would be at increased risk for falls and functional decline. R4 was modified independence with contact guard assistance (one or two hands on body to support balance or steady body) for transfers. R4's admission Minimum Data Set (MDS) dated [DATE], identified R4 needed supervision or touching assistance for transfers and had moderate cognitive impairment. R4's fall care plan focus dated 4/22/25, identified R4 was at risk for falls due to Parkinson's disease. Goal of will not sustain a fall related injury through review date. With interventions of education on prevention, reduction precautions per facility protocol. R4's care plan did not identify what level of transfer assistance R4 required as per the PT evaluation dated 4/22/25 nor the level of assistance that was identified on the MDS dated [DATE]. R4's nursing assistant care sheet dated 4/22/25, identified R4 was assist x1 with gait belt and walker for transfers. R4's physician note dated 5/1/25, identified R4 was still working with therapy and is not back to her baseline strength or balance and does not feel ready to go home. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R4's fall safety event dated 5/10/25 at 1:45 p.m , identified R4 had a witnessed fall in her room during a transfer without assistance. During the transfer R4's feet became entangled in the nightstand, which caused her to lose her balance, fall, and landed on her right hip. R4 had pain in right femur area and was sent to emergency department (ED) for evaluation. R4's emergency department (ED) note dated 5/10/25, identified R4 had been seen in ED following a fall in the nursing home and had subsequent hip pain and unable to bear weight. Imaging showed moderately displaced intertrochanteric fracture of the proximal right femur. R4's hospital operative note dated 5/11/25, identified R4 underwent insertion of intramedullary nail of right femur following a fall in the nursing home. R4's interdisciplinary team (IDT) progress note dated 5/12/25 at 10:12 a.m., identified review of fall on 5/10/25 that R4 was ambulating in room with a staff member present with a gait belt on, however he stepped back as resident was attempting to brush her hair near the nightstand. Staff visualized R4's feet got tangled up in the nightstand when attempting to turn, causing her to lose balance and fall. Staff member was not within close reach to catch R4 from falling. Staff interviews reveal that R4 had a history of ambulating in her room without assistance. R4 was an assist of one with a walker for transfers and ambulation prior to the fall. R4's activities of daily living care plan dated 5/12/25 was revised after her fall on 5/10/25, to include the level of staff assistance R4 required which was, limited assist of one for transfers with a gait belt and walker. R4's progress note dated 5/14/25, identified R4 returned from the hospital and was substantial/maximum assistance for all transfers. During an interview on 5/15/25 at 1:38 p.m., nursing assistant (NA)-B referenced the nursing assistant care sheets as the care plan that gives them direction on how to care for a resident. During an interview on 5/15/25 at 3:55 p.m., nursing assistant (NA)-D stated he was assisting R4 in her room at the time of her fall on 5/10/25. NA-D placed a gait belt on R4 and ambulated her next to the nightstand so she could brush her hair, he then left her at the nightstand and went to get her walker when she must have turned and got her feet tangled on the nightstand and fell to the ground. NA-D stated he was not standing near R4 at that time, and when she lost her balance, he was not able to catch her. During an interview on 5/15/25 at 12:40 p.m., licensed practical nurse (LPN)-C stated R4's nursing assistant care sheet identified R4's transfer status of assist of one staff on admission, however R4's care plan did not identify how she was transferred until 5/12/25 after it was reviewed after the fall. During an interview on 5/15/25 at 4:36 p.m., registered nurse regional director (RNRD) stated her expectation would be for staff to transfer resident per plan of care and ensure adequate supervision is provided during the transfers to maintain safety and that any resident would have their care plans updated in a timely manner. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Integrated Fall Management Policy dated 9/23, identified residents with risk for falling will have interventions implemented through their resident centered plan of care. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. The following corrective actions were verified as implemented prior to the survey: 1. A four-point plan of correction was initiated on 5/12/25: a. Specific action taken for identified resident. b. Resident sent to ED for treatment. c. NA suspended pending investigation. d. Updated provider and family. e. Report filed with state agency. f. Interview of NA involved. g. Interviewed therapy. h. Interviewed like residents with no concerns identified. 2. Root cause of R4's fall identified that NA was not following the plan of care and that R4 should have been assist of one with a gait belt. 3. Identified all residents that ambulate with staff assistance may be at risk for the same deficient practice. 4. Educated the NA involved in the incident regarding following plan of care for ambulation status. Education provided to all NA and nurses regarding following plan of care for residents. 5. Ensured all residents had the correct ambulation status on care plan and nursing assistant care sheets. 6. Education of all staff regarding abuse and neglect, reporting policy, expectations including timeframe. 7. Monitoring will be done via audits of direct audit of staff during resident ambulation five times per week x 4 weeks, three times per week x 4 weeks, one time per week for 4 weeks x 4 weeks. Audits will be brought to quality assurance performance improvement (QAPI) to determine ongoing audits. 8. Director of Nursing of designee will be responsible for the compliance of the action plan. 51576

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on observation, interview, and document review, the facility failed to provide sufficient staffing to ensure residents received the care and assistance they needed in a timely manner for 4 of 5 residents (R5, R1, R3, & R6) reviewed for call lights. This caused actual harm to R5 when she waited nearly three hours for her call light to be answered causing her to experience increased anxiety, distress, fear, and feelings of worthlessness and helplessness. Findings include: R5 R5's Minimum Data Set (MDS) assessment dated [DATE], indicated she had intact cognition and no behaviors or rejections of care. R5 had diagnoses including multiple sclerosis (chronic disease affecting the central nervous system), anxiety disorder, major depressive disorder, and morbid obesity. R5 was frequently incontinent of bowel and bladder and required substantial staff assistance with toileting hygiene, bathing, dressing, and mobility in bed. R5 was dependent on staff for transfers and used a motorized wheelchair independently. R5's urinary incontinence care plan interventions dated 2/11/25, included keep call light within reach, provide incontinence care after each incontinent episode, toilet per request, and staff to toilet every two hours and as needed with extensive assistance. R5's activities of daily living (ADL) care plan included intervention dated 2/11/25, to discuss with staff how to honor R5's preferences and provide care in a timely manner. R5's psychosocial well-being care plan dated 1/15/25, identified potential for trauma related to history of sexual abuse, physical abuse, and mental abuse. Interventions dated 1/15/25 included observe for signs of adjustment difficulties such as inability to pursue interests or activities or sad or anxious mood. R5's mood state care plan dated 5/26/22 identified R5 was at increased risk for mood issues related to anxiety disorder, suicidal ideations in the setting of delirium, toxic encephalopathy, new an unfamiliar environment, and legal blindness. Intervention dated 5/16/24, noted psychology was to evaluate and treat as needed. R5's psychology provider note by licensed independent clinical social worker (LICSW)-A dated 1/31/25, indicated R5 had diagnoses including major depressive disorder and anxiety disorder. R5's mental status exam noted dysthymic (mild long-lasting depressed) mood, ruminating (persistent negative) thoughts, tearful affect, and tearful behavior. R5 reported an incident of waiting for her brief to be changed after a bowel movement (BM), which she believes contributed to current UTI [urinary tract infection]. Treatment recommendations included it remains of benefit for [R5] to have brief changes after BM's as soon as possible, to reduce risk of developing UTI's which she seems to be prone to. This would aid in decreasing anxiety levels. R5's psychology provider note by LICSW-A dated 2/21/25, indicated R5 presented with anxious and depressed mood of sadness, overwhelmed, grief, stress, difficulty concentrating, and fatigue. R5 reported she had another UTI and endorsed anxiety around this. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	R5's Long Term Care Social Service assessment dated [DATE], indicated she had mood appropriate to circumstance and mood was affected by diagnoses. She did not have mood symptoms of depression, crying, or withdrawal from activities and her mood was not restless, anxious, or inclusive of complaints. R5 was identified as expressing her feelings openly and coping well. She did not distort or misrepresent events, worry/deny/cry, or display ineffective coping skills such as distancing self, anger, or withdrawal from life at facility. The facility's Grievances Log included a grievance entry dated 4/26/25 voiced by R5. The concern section noted R5 reported on Saturday 4/26/25 around 3:00 p.m. she put on her call light for assistance transferring from chair to commode and waited an hour for a nurse to come in. The nurse said she was going to turn the call light off and then back on and let a nursing assistant (NA) know she was waiting. R5 requested the call light not be turned off as she hadn't been assisted yet. Nurse left call light on and informed a NA who then assisted. The findings section of the log noted The resident's call light was not answered for approximately one hour after activation on Saturday, 4/26, around 3:00 PM. When a nurse eventually responded, she did not provide direct assistance but informed an aide, who later assisted the resident. The nurse initially planned to reset the call light before notifying staff, but the resident requested it remain on until assistance was received. The action section noted Staff were reminded of the importance of promptly responding to call lights to ensure residents receive timely assistance. Nursing staff were specifically instructed not to reset a call light until the resident's needs have been fully addressed. The situation was reviewed with the care team to reinforce effective communication practices and appropriate procedures for escalating any delays in care. The resident was informed of the concern and the steps being taken to address it. R5's Device Activity Report (call light log) dated 4/12/25 through 5/14/25, included but was not limited to the following reset times (time from when light is activated to when it is cleared): - 4/12/25 at 7:27 p.m., 20 minutes and 46 seconds - 4/12/25 at 10:40 p.m., 25 minutes and 48 seconds - 4/13/25 at 7:57 a.m., 100 minutes and 22 seconds - 4/15/25 at 2:09 p.m., 21 minutes and 35 seconds - 4/16/25 at 5:05 p.m., 29 minutes and 19 seconds - 4/17/25 at 3:37 p.m., 24 minutes and 32 seconds - 4/19/25 at 7:57 a.m., 23 minutes and 7 seconds - 4/20/25 at 8:50 a.m., 43 minutes and 48 seconds - 4/20/25 at 12:58 p.m., 61 minutes and 51 seconds - 4/20/25 at 9:45 p.m., 22 minutes and 36 seconds - 4/22/25 at 7:38 a.m., 34 minutes and 54 seconds (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	- 4/22/25 at 1:18 p.m., 49 minutes and 30 seconds - 4/22/25 at 9:54 p.m., 28 minutes and 3 seconds - 4/25/25 at 1:16 p.m., 26 minutes and 8 seconds - 4/26/25 at 7:13 a.m., 202 minutes and 18 seconds - 4/26/25 at 3:38 p.m., 64 minutes and 31 seconds - 4/26/25 at 5:50 p.m., 20 minutes and 30 seconds - 4/27/25 at 5:40 p.m., 30 minutes and 14 seconds - 4/28/25 at 6:01 p.m., 32 minutes and 32 seconds - 5/3/25 at 1:03 p.m., 22 minutes and 52 seconds - 5/6/25 at 7:41 a.m., 57 minutes and 32 seconds - 5/6/25 at 1:00 p.m., 43 minutes and 42 seconds - 5/6/25 at 5:20 p.m., 26 minutes and 2 seconds - 5/7/25 at 7:34 a.m., 24 minutes and 35 seconds - 5/7/25 at 5:57 p.m., 31 minutes and 49 seconds - 5/10/25 at 12:12 p.m., 174 minutes and 8 seconds - 5/11/25 at 12:58 a.m., 20 minutes and 55 seconds - 5/11/25 at 2:12 p.m., 59 minutes and 19 seconds - 5/11/25 at 7:17 p.m., 26 minutes and 51 seconds - 5/12/25 at 3:16 p.m., 31 minutes and 41 seconds - 5/13/25 at 3:24 p.m., 18 minutes and 14 seconds - 5/13/25 at 5:52 p.m., 29 minutes and 34 seconds (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/14/25 at 2:19 p.m., R5 stated there are huge issues with call lights. R5 stated at night sometimes nobody would answer her call light so she would have to use a telephone to call the nursing station on her unit and another unit to request assistance. R5 explained on a good day call lights are answered in 15 minutes, on a bad day anytime between half an hour and 45 minutes, and on a real bad day a lot longer. R5 noted there were occasions she had to wait marathon times with the most recent incident on Saturday 5/10/25. R5 stated a nursing assistant (NA) got her up and dressed in the morning and told her the NA assigned to her had left sick an hour into the day shift. The NA who had helped her was then pulled and put on a medication cart to work as a medication aide because they were short a nurse, leaving one NA working the whole floor. R5 stated around 12:15 p.m. she turned her call light on because she needed to have her brief changed. She was sitting in her recliner, it was nice out, and she wanted to go outside. She turned on the light to have her brief changed and transfer to her electric wheelchair to go outside. R5 stated, no one came until 3:15 in the afternoon, nobody came, not one person to check on me. Review of R5's call light log identified her call light was activated on 5/10/25 at 12:12 p.m. and was not reset for 2 hours 54 minutes and 8 seconds. R5 stated the evening shift NA stopped in her room while orienting another NA who was agency staff and they were not aware her light was on when they came by, but R5 told them what she needed. R5 stated she was a [NAME] of a [NAME] [sic] by this point, I was angry at being ignored, I was terrified that here I am again, and grateful I wasn't in serious physical danger. R5 noted this could have been fatal to somebody so yeah, I'm grateful for that, but I'm afraid, it makes me afraid about being here. I'm never safe here. After she was assisted to the commode she had NAs put her in bed. R5 was afraid by that time, she didn't know who was going to be working that night. She didn't feel comfortable enough to be in her wheelchair and go outside. I thought just put me in my bed so I can be as safe as possible. R5 noted the facility had been staggering nurses and instead of two nurses starting at 3:00 p.m. they had one start at 3:00 p.m. and one start at 5:00 p.m. which made R5 not feel secure and safe. R5 stated I don't think emotionally I have recovered R5 did not feel safe in the late afternoon or early morning because staff don't help. R5 explained another recent instance where she waited an extended time for assistance. R5 had a large BM and had BM all over herself. She informed an NA that she needed assistance because I know I needed to be changed, and I needed to be changed fast because I didn't want to have another UTI. R5 indicated the NA told her he needed to finish passing out lunch trays and collecting them and would then get to her. R5 then went to the nursing station and informed staff she needed to be changed now, went back to her room, and turned on her call light. After 15 to 20 minutes, she left her room in her wheelchair to find the NA, told him she needed to be changed now, he stated he had to do something else first, and she returned to her room. After waiting another 15 to 20 minutes she went looking for him again, and he again said he had to go do something in another room. After 15 to 20 more minutes, she found him again and he did it again a third time. R5 stated she lost it and went back to my room and she wept and wailed. After about five minutes, the NA arrived and asked why she was crying and she said because you won't change me. The NA got a second NA and the two then assisted with cleaning her up. R5 stated she was very upset by this incident. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/15/25 at 12:05 p.m., trained medication aide (TMA)-A stated aides answer call lights and other staff don't answer call lights, but they should. TMA-A noted it was hard to answer call lights with three aides and sometimes two working. TMA-A stated ten minutes was too long to take to answer a call light and if somebody needs to go to the bathroom they can't wait, we don't have enough staff to do that. TMA-A stated with two aides it is a struggle. If we had more staff it would be helpful with call lights. TMA-A noted R5 used the call light when she needed to use the commode or wanted to come out of her room and staff did not have time because two people were needed to transfer R5. TMA-A stated, R5 did get upset about the call light after waiting, her face changes, she is mad. During an interview on 5/15/25 at 12:26 p.m., registered nurse (RN)-C stated there were not enough staff to do what needed to be done for the residents and answer call lights like we should. RN-C stated she thought the recent instance when R5 had to wait approximately three hours for her call light to be answered was sad and it's obvious how you would feel, neglected, afraid. RN-C explained there should be three aides at all times and noted call lights were more of a problem when there were less than three NA's working on the unit. During an interview on 5/15/25 at 9:50 a.m., staffing coordinator (SC) reviewed the schedule from Saturday 5/10/25 for R5's unit. She noted the day shift had two nurses, an RN from 6:30 a.m. to 1:00 p.m. and an LPN from 6:30 a.m. to 3:00 p.m. The day shift had three NA's working, with two scheduled from 6:30 a.m. to 2:45 p.m. and one scheduled from 6:30 a.m. to 3:00 p.m. The NA scheduled to work until 3:00 p.m. came in for about an hour in the morning, became sick and left, and another NA came in to replace her. The evening shift had two nurses and two NA's. One LPN was scheduled from 3:00 p.m. to 8:00 p.m. and the second LPN scheduled from 4:00 to 11:00 p.m. called out and was replaced by an RN pulled from a different unit. Three NA's were scheduled to work: one from 2:30 p.m. to 11:00 p.m., one from 3:00 p.m. to 11:00 p.m., and one from 3:00 p.m. to 9:00 p.m. Two NA's worked the evening shift as the third was pulled to a different unit to work as a TMA. The SC stated one of the aides from another unit was probably floating between their assigned unit and R5's unit. During an interview on 5/15/25 at 4:33 p.m., the nurse manager for R5's unit, RN-D, stated she didn't know what was going on with call lights, we need to work on getting those lights. Call lights should be answered in no more than five minutes. If a light was not answered timely a resident would may not feel good about it or disappointed, RN-D noted she wouldn't be happy. RN-D recalled the instance on 4/26/25 when R5 had to wait an hour for her call light to be answered and thought it was because an aide had been sick and left early. RN-D stated she talked to R5 about this and she was not happy. Whoever saw the light should have answered right away and it was unacceptable. RN-D had also spoken with R5 about the instance on 5/10/25 when she waited approximately three hours for her call light to be answered and R5 wasn't happy. Long call lights had a negative effect on residents when they had to wait that long for assistance and it was definitely something we need to work on with the call lights, whether it is a weekend or not. Regarding how long call light times affected R5, RN-D stated she knew for sure R5 did get anxious and worried because R5 had told as much. RN-D stated she had not looked into how call light logs compared to staffing and hadn't heard from her staff that they were related. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/15/25 at 4:00 p.m., the director of social services (DSS) stated long call light wait times are negative towards people's psychosocial well-being and could make residents not trust our staff, could impact how people feel about being safe here. The DSS noted some residents could get a lot more anxious if their call lights were not being answered, especially if they already have anxiety. An increase in anxiety would be considered a negative impact to psychosocial well-being. The DSS reviewed her concerns (grievances) database and noted a concern from R5 on 5/10/25 that her call light was on for three hours and noted staff were still looking into this with nurse manager RN-D assigned to investigate. She identified an additional concern from R5 dated 4/26/25 when she waited for over an hour for her light to be answered which was confirmed when staff reviewed call light logs. The DSS assumed this impacted R5 negatively, could be harmful, and probably increased her anxiety levels. The DSS noted waiting one or three hours for a call light to be answered could impact a resident's sense of dignity or self-worth. She expected call lights to be answered no later than 20 minutes and long call light wait times wouldn't feel good. During a return phone call interview on 5/19/25 at 4:45 p.m., licensed independent clinical social worker (LICSW)-A stated she had been seeing R5 since she admitted to the facility and saw R5 for her depression, chronic adjustment distress, anxiety, and post-traumatic stress symptoms. LICSW-A was aware of R5's long call light times, including the one that took staff three hours to answer. LICSW-A noted in response to the long call light times it made R5 feel helpless, a lack of control, and like her needs don't matter. R5 was reliant on staff to use the bathroom or get transferred. Long call light wait times certainly impacts her [R5's] anxiety levels. R5's reported three-hour wait time was a long wait time, I would expect that most people would feel pretty distressed by that. LICSW-A felt R5's distress level and response is completely understandable and appropriate to the situation. LICSW-A also noted R5 had brought up call light wait times with her previously. LICSW-A believed it did impact R5's mood and feeling of lack of being in control of her situation. Additionally, feeling of helplessness that R5 requested help and not only has it not arrived, but then she has had to wait for that long amount of time. LICSW-A stated for R5 it kind of filters into her thought of do my needs matter?' and when her call light was not answered timely she feels depressed. R5 was angry and tearful when talking about this experience. LICSW-A stated for her to wait that long, that is harmful to her. R5 had filed multiple complaints and grievances and spoken with facility staff and the ombudsman, but there has not been any improvement so she worries. LICSW-A noted R5 had expressed fears about what could happen to her in the time frame while she was waiting for a call light to be answered, and the worry had been kind of steady. LICSW-A noted adjusting to the facility has been very difficult for her [R5] and long call light wait times doesn't help. LICSW-A noted R5 had been better adjusted over the last year and a half but then if a circumstance like this comes up it brings her back to some of those feelings. R1 R1's MDS assessment dated [DATE], indicated she had intact cognition and no behaviors or rejections of care. R1 had diagnoses including Parkinson's disease, acute pain due to trauma, back pain, and abnormalities of gait and mobility. She was occasionally incontinent of urine, and required substantial staff assistance with toileting, bathing, bed mobility, and transfers. (continued on next page)

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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 0725 Level of Harm - Actual harm Residents Affected - Few	R1's mobility care plan dated 3/1/25, identified she needed staff assistance with bed mobility, transfers, ambulation, and locomotion due to immobility. Intervention dated 5/12/25, directed staff to ensure the call light was in reach and encourage R1 to use it to make needs known. R1's urinary care plan with interventions dated 2/11/25, directed staff to keep call light in reach, toilet every two to three hours and as needed, and toilet per request. Her communication care plan dated 2/11/25, identified R1 preferred to have her call light on the table in her room and would also like to have a bell to ring if she needed assistance. Intervention dated 2/11/25, directed to discuss with staff how to honor preferences and provide care in a timely manner. R1's call light log dated 4/12/25 through 5/14/25, included but was not limited to the following reset times: - 4/12/25 at 11:05 a.m., 28 minutes and 46 seconds - 4/12/25 at 5:32 p.m., 33 minutes and 39 seconds - 4/12/25 at 8:24 p.m., 26 minutes and 58 seconds - 4/13/25 at 8:27 a.m., 25 minutes and 25 seconds - 4/13/25 at 9:17 a.m., 32 minutes and 59 seconds - 4/13/25 at 12:37 p.m., 34 minutes and 42 seconds - 4/15/25 at 12:21 p.m., 21 minutes and 39 seconds - 4/16/25 at 10:57 a.m., 18 minutes and 41 seconds - 4/16/25 at 12:20 p.m., 31 minutes and 20 seconds - 4/16/25 at 5:20 p.m., 24 minutes and 22 seconds - 4/16/25 at 7:32 p.m., 32 minutes and 38 seconds - 4/19/25 at 1:38 a.m., 26 minutes and 51 seconds - 4/20/25 at 11:12 a.m., 29 minutes and 16 seconds - 4/20/25 at 3:56 p.m., 23 minutes and 32 seconds - 4/20/25 at 7:41 p.m., 36 minutes and 34 seconds - 4/21/25 at 10:01 a.m., 36 minutes and 51 seconds - 4/22/25 at 12:28 p.m., 24 minutes and 18 seconds - 4/24/25 at 9:13 a.m., 265 minutes and 5 seconds (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	05/15/2025

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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 0725 Level of Harm - Actual harm Residents Affected - Few	- 4/24/25 at 1:40 p.m., 29 minutes and 14 seconds - 4/20/25 at 10:38 a.m., 22 minutes and 34 seconds - 5/3/25 at 10:52 a.m., 46 minutes and 44 seconds - 5/4/25 at 1:54 p.m., 53 minutes and 24 seconds - 5/5/25 at 6:09 p.m., 19 minutes and 12 seconds - 5/6/25 at 11:47 a.m., 24 minutes and 4 seconds - 5/6/25 at 5:39 p.m., 31 minutes and 19 seconds - 5/7/25 at 9:56 a.m., 22 minutes at 24 seconds - 5/7/25 at 5:56 p.m., 26 minutes and 44 seconds - 5/7/25 at 9:46 p.m., 49 minutes and 43 seconds - 5/10/25 at 8:06 a.m., 67 minutes and 58 seconds - 5/10/25 at 9:40 a.m., 21 minutes and 56 seconds - 5/10/25 at 5:27 p.m., 31 minutes and 21 seconds - 5/10/25 at 6:03 p.m., 21 minutes and 49 seconds - 5/11/25 at 10:22 a.m., 24 minutes and 52 seconds - 5/11/25 at 1:32 p.m., 30 minutes and 56 seconds - 5/12/25 at 7:56 p.m., 27 minutes and 33 seconds During an interview on 5/12/25 at 3:08 p.m., R1 stated things aren't going well. Staff would not answer the light. R1 had a bell that one of the nurses gave him and directed R1 that if staff did not answer the call light in a reasonable time, to use the bell. R1 stated I do scream and staff would tell R1 to quit it. Staff would not answer the bell either, so R1 gave it away. R1 stated she would press her call light and wait so long that she turned it off because staff didn't answer. R1 stated she had fallen recently while trying to organize laundry in her room and staff told her to use her call light for assistance, but that was a joke because staff don't answer her light and have said they are shorthanded. R1 stated she used her call light when she needed to use the bathroom but staff don't answer, so I end up going in my pull-ups because she couldn't hold it for that long. R1 stated she felt helpless, and it sometimes took one or two hours for her call light to be answered. She stated, I am bitter because I had to mess myself because she could not get staff to come help her. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 5/12/25 at 5:18 p.m., a call light digital alarm board in the hallway displayed displayed alarm [R1's room number] 15 minutes and was flashing. NA-C entered R1's room. R1's call light log indicated her light was activated on 5/12/25 at 5:00 p.m. and was not cleared for 17 minutes and 58 seconds. Upon exiting, NA-C stated R1 wanted to go to the bathroom and usually if her call light is on it is because she wanted water or to go to the bathroom. NA-C stated she had taken R1 to the bathroom and cleaned her up after toileting. During an interview on 5/13/25 at 9:23 a.m., R1's friend and power of attorney (POA)-A stated R1 had called her crying before, stating she's uncomfortable, needed to get up, needed to go to the bathroom, and needed pain medication. POA-A told R1 to ring her bell while still on the phone to see if staff come in and she's ringing the bell, and nothing happens. POA-A stated this was not okay. R3 R3's MDS assessment dated [DATE], indicated she had intact cognition and no behaviors or rejections of care. R3 had diagnoses including stage four pressure ulcer of the sacral region (wound with full thickness tissue loss and exposed bone, tendon, or muscle over the tailbone area), low back pain, heart failure, non-Alzheimer's dementia, and depression. She was occasionally incontinent of bowel and bladder and required supervisory staff assistance with toileting hygiene and bathing, and partial assistance with footwear and walking. R3's urinary care plan included interventions dated 2/13/25, including keep call light within reach, staff to toilet every two to three hours and as needed with assist of one staff, and toilet per request. R3's routines care plan included intervention dated 2/13/25, directing discuss with staff how to honor my preferences and provide care in a timely manner. R3's activities of daily living care plan included interventions dated 8/9/24, I can verbally ask for assistance, I need assistance to help me remain free from skin breakdown and respect my dignity. Her pain care plan included a goal dated 5/3/25, to be comfortable. Intervention dated 9/5/24, noted interventions for pain included prescribed medications, relaxation, and distraction. R3's call light log dated 4/12/25 through 5/14/25, included the following reset times: - 4/12/25 at 5:20 p.m., 40 minutes and 21 seconds - 4/20/25 at 12:21 p.m., 26 minutes and 36 seconds - 4/21/25 at 12:11 p.m., 49 minutes and 11 seconds - 4/21/25 at 3:45 p.m., 36 minutes and 22 seconds - 4/26/25 at 8:53 a.m., 106 minutes and 54 seconds - 4/28/25 at 7:04 p.m., 44 minutes and 12 seconds - 4/30/25 at 8:41 a.m., 17 minutes and 2 seconds - 5/1/25 at 8:46 a.m., 51 minutes and 35 seconds (continued on next page)

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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 0725 Level of Harm - Actual harm Residents Affected - Few	- 5/4/25 at 12:21 p.m., 17 minutes and 43 seconds - 5/5/25 at 9:10 a.m., 124 minutes and 52 seconds - 5/5/25 at 12:52 p.m., 45 minutes and 40 seconds - 5/5/25 at 2:54 p.m., 33 minutes and 14 seconds - 5/7/25 at 7:36 a.m., 114 minutes and 47 seconds - 5/7/25 at 12:56 p.m., 32 minutes and 41 seconds - 5/8/25 at 1:15 p.m., 56 minutes and 11 seconds - 5/10/25 at 9:47 a.m., 105 minutes and 27 seconds - 5/10/25 at 6:34 p.m., 75 minutes at 14 seconds - 5/11/24 at 9:02 a.m., 119 minutes and 15 seconds - 5/13/25 at 11:01 a.m., 24 minutes 35 seconds - 5/14/25 at 8:38 p.m., 38 minutes and 14 seconds On 5/13/25 at 11:04 a.m., NA-A stated staffing was short sometimes, and they could use a little help. NA-A noted call lights should be answered in either eight to 10 minutes or five to eight minutes, she couldn't remember. NA-A noted she would usually turn call lights off right away and then go look for someone to help her if she was unable to provide the needed assistance. She stated answering call lights can be a challenge and lights were usually on for thirty minutes plus which was pretty bad and a long time. NA-A noted she wouldn't like this if it was her family member. At 11:24 a.m., a call light digital alarm board in the hallway displayed alarm [R3's room number] 20 minutes and was flashing. NA-A entered R3's room and stated she was there because R3's call light was on and confirmed it had been on for 20 minutes. During an interview on 5/13/25 at 11:24 a.m., R3 stated it had been a while since she pressed her call light. R3 asked NA-A for as needed pain medication for back pain rated six out of 10. R3 thought nursing staff all went on break every hour because it sometimes took a long time for call lights to be answered. R3 noted call light wait times were not timely around mealtimes, as staff were busy preparing and serving meals and passing trays. R3 stated she realized staff were busy and she just had to be patient, but sometimes staff got mad and then they ignore you. R6 (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	R6's MDS assessment dated [DATE], indicated she had intact cognition and no behaviors or rejections of care. R6 had diagnoses including encephalopathy (disturbance in brain's function), sclerosis, anxiety, depression, and functional quadriplegia (complete inability to move all four limbs due to extreme debility or frailty). She was frequently incontinent of bowel and had an indwelling urinary catheter. R2 was dependent on staff for assistance with all cares, activities of daily living, and mobility. R6's mobility care plan dated 2/13/25, identified she needed assistance due to functional quadriplegia. Intervention dated 5/7/26, directed staff to ensure call light is in resident's reach while in room and encourage to use it to make needs known. R6's communication care plan dated 4/24/25, noted she used a specialized call light she accessed with her face/chin. R6's urinary care plan included interventions dated 2/13/25, including keep call light within reach, staff to toilet every two to three hours and as needed, and toilet per request. R6's call light log dated 4/12/25 through 5/14/25, included the following reset times: - 4/13/25 at 8:56 a.m., 58 minutes and 55 seconds - 4/18/25 at 2:38 p.m., 18 minutes and 4 seconds - 4/20/25 at 5:10 a.m., 28 minutes and 8 seconds - 4/20/25 at 7:04 a.m., 37 minutes and 0 seconds - 4/20/25 at 9:26 a.m., 30 minutes and 55 seconds - 4/20/25 at 11:00 a.m., 55 minutes and 37 seconds - 4/20/25 at 12:56 p.m., 51 minutes and 14 seconds - 4/21/25 at 9:20 a.m., 22 minutes and 45 seconds - 4/21/25 at 10:10 a.m., 43 minutes and 0 seconds - 4/21/25 at 1:31 p.m., 25 minutes and 3 seconds - 4/21/25 at 7:13 p.m., 23 minutes and 59 seconds - 4/22/25 at 5:22 a.m., 20 minutes and 4 seconds - 4/22/25 at 7:39 a.m., 30 minutes and 28 seconds - 4/22/25 at 9:16 a.m., 36 minutes and 43 seconds - 4/22/25 at 10:02 a.m., 20 minutes and 31 seconds - 4/24/25 at 11:22 a.m., 20 minutes and 36 seconds (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	- 4/24/25 at 5:01 p.m., 18 minutes and 47 seconds - 4/25/25 at 2:08 p.m., 19 minutes and 55 seconds - 4/25/25 at 2:35 p.m., 18 minutes and 50 seconds - 4/26/25 at 5:11 a.m., 60 minutes and 40 seconds - 4/26/25 at 6:41 a.m., 96 minutes and 29 seconds - 4/26/25 at 9:32 a.m., 55 minutes and 11 seconds - 4/26/25 at 10:54 a.m., 61 minutes and 9 seconds - 4/26/25 at 12:21 p.m., 34 minutes and 50 seconds - 4/26/25 at 2:26 p.m., 18 minutes and 4 seconds - 4/26/25 at 3:27 p.m., 31 minutes and 45 seconds - 4/27/25 at 2:34 p.m., 18 minutes and 50 seconds - 4/27/25 at 3:36 p.m., 36 minutes and 5 seconds - 4/27/25 at 5:30 p.m., 22 minutes and 24 seconds - 4/27/25 at 10:07 p.m., 50 minutes and 2 seconds - 4/28.25 at 5:25 a.m., 19 minutes and 3 seconds - 4/28/25 at 10:46 a.m., 48 minutes and 21 seconds - 4/29/25 at 7:50 a.m., 21 minutes and 13 seconds - 4/30/25 at 2:24 p.m., 23 minutes and 32 seconds - 5/1/25 at 10:56 a.m., 18 minutes and 32 seconds - 5/2/25 at 6:30 a.m., 28 minutes and 24 seconds - 5/2/25 at 7:09 a.m., 51 minutes and 11 seconds - 5/2/25 at 11:41 a.m., 36 minutes and 59 seconds - 5/4/25 at 5:40 a.m., 37 minutes and 11 seconds - 5/4/25 at 12:08 p.m., 29 minutes and 32 seconds (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	- 5/4/25 at 1:49 p.m., 27 minutes and 39 seconds - 5/4/25 at 1:18 p.m., 21 minutes and 34 seconds - 5/5/25 at 5:28 a.m., 29 minutes and 18 seconds - 5/5/25 at 8:37 a.m., 28 minutes and 18 seconds - 5/5/25 at 10:43 a.m., 20 minutes and 1 second - 5/5/25 at 1:49 p.m., 22 minutes and 15 seconds - 5/5/25 at 2:38 p.m., 54 minutes and 56 seconds - 5/5/25 at 6:58 p.m., 71 minutes and 0 seconds - 5/6/25 at 12:04 p.m., 26 minutes and 50 seconds - 5/7/25 at 4:17 p.m., 25 minutes and 59 seconds - 5/10/25 at 7:28 a.m., 45 minutes and 41 seconds - 5/10/25 at 9:53 a.m., 63 minutes and 46 seconds - 5/10/25 at 12:58 p.m., 106 minutes and 44 seconds - 5/10/25 at 2:46 p.m., 81 minutes and 29 seconds - 5/10/25 at 5:43 p.m., 72 minutes and 11 seconds - 5/10/25 at 7:26 p.m., 29 minutes and 53 seconds - 5/10/25 at 10:18 p.m., 32 minutes and 12 seconds - 5/11/25 at 3:47 a.m., 27 minutes and 26 seconds - 5/11/25 at 9:19 a.m., 92 minutes and 53 seconds - 5/11/25 at 7:13 p.m., 19 minutes and 51 seconds - 5/11/25 at 7:40 p.m., 20 minutes and 37 seconds - 5/11/25 at 10:00 p.m., 43 minutes and 56 seconds - 5/12/25 at 12:13 p.m., 36 minutes and 55 seconds - 5/12/25 at 3:23 p.m., 26 minutes and 10 seconds (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	- 5/13/25 at 7:33 a.m., 44 minutes and 6 seconds - 5/14/25 at 9:32 a.m., 37 minutes and 47 seconds During an interview on 5/14/25 at 3:05 p.m., R6 stated she used her chin to press her specialized call light. R6 stated that when she used her call light staff sometimes came right away and sometimes who knows when they would come. R6 stated it pissed her off when staff didn't answer her call light in a timely manner and it doesn't feel very good. She noted some staff would turn her call light off and leave without helping and she sometimes had to wait a really long time for assistance. R6 noted she had limited mobility and that's why she used the call light for staff assistance, such as when she wanted a sip of water. During an interview on 5/14/25 at

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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 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** 49338 Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and failed to identify and report medication errors for 2 of 3 (R1, R2) residents reviewed for medication administration. Findings include: R1 R1's Minimum Data Set (MDS) assessment dated [DATE], indicated she admitted to the facility on [DATE] with diagnoses including acute pain due to trauma and dorsalgia (pain in the upper back). R1 was on a scheduled pain medication regimen and received as needed (PRN) pain medications. R1's care plan revised 2/6/25, identified R1 experienced pain and discomfort. Interventions included administration of scheduled and PRN pain medication. R1's care plan also identified risk for alteration of skin status. Interventions included ensuring protective skin measures (barrier cream to dry areas and wheelchair cushion) were in place. R1's physician orders included an order for miconazole nitrate 2% topical cream (antifungal cream used to treat fungal or yeast infections) with start date 10/29/24 and discontinue date 5/15/25. Instructions were to apply to affected area topically twice daily scheduled for administration once between 7:00 a.m. and 3:00 p. m. (day) and again between 3:00 p.m. and 11:00 p.m. (evening). R1's physician orders included an order for tramadol oral tablet (an opioid pain medication used to treat moderate to moderately severe pain) 50 milligrams (mg) strength with start date 1/30/25. Instructions were to administer 25 mg orally four times a day for pain scheduled for administration at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R1's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled twice daily administrations of miconazole. Documentation of the miconazole as not administered included: - 3/1/25 day and evening doses with notes drug/item unavailable - 3/3/25 evening dose with comment on order - 3/6/25 evening dose with note drug/item unavailable - 3/7/25 day and evening doses with notes drug/item unavailable - 3/8/25 day dose with note drug/item unavailable - 3/15/25 day dose with note drug/item unavailable (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/4/25 evening dose with note drug/item unavailable - 4/5/25 day and evening doses with notes drug/item unavailable - 4/6/25 day and evening doses with notes drug/item unavailable - 4/7/25 day dose with note drug/item unavailable - 4/24/25 evening dose with note drug/item unavailable - 4/25/25 day and evening doses with notes drug/item unavailable - 4/26/25 day and evening doses with notes drug/item unavailable - 5/2/25 day and evening doses with notes drug/item unavailable - 5/4/25 day dose with note drug/item unavailable - 5/7/25 day dose with note drug/item unavailable R1's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled four daily administrations of tramadol. Documentation of the tramadol as not administered included: - 4/11/25 at 4:00 p.m. with note drug/item unavailable - 4/24/25 at 8:00 p.m. with note med[ication] not here called pharmacy - 4/25/25 at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. with notes drug/item unavailable - 4/26/25 at 8:00 a.m., 12:00 p.m., and 4:00 p.m. with notes drug/item unavailable R1's progress notes dated 4/24/25 at 6:45 p.m. and 6:55 p.m., indicated insurance would not cover the current dose of tramadol and wanted to change the dose. The pharmacy sent a fax to the facility to change the tramadol orders, R1 had no more tramadol available, and the on-call provider was notified. The on-call provider approved the pharmacy changing the tramadol order with new order for 50 mg tablets, give half tablet four times daily and once daily as needed for pain. Per pharmacy, insurance would cover this dose. Review of R1's progress notes did not identify further documentation regarding availability of the tramadol or miconazole, missed administrations, or related provider notifications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 11:53 a.m., licensed practical nurse (LPN)-A stated on 4/24/25, R1 only had one remaining tramadol tablet. She contacted the pharmacy to re-order, was told R1's insurance would no longer cover this tablet, and contacted the on-call provider for approval to change from 25 mg tablets to 50 mg tablets cut in half. LPN-A stated she notified the provider to get approval, but did not notify the provider of the missed dose at 8:00 p.m. when the medication was unavailable because she assumed the medication would arrive later that night after her shift ended. LPN-A stated if a medication was not administered, the physician should be notified and missed doses of medications without a provider order to hold were medication errors. LPN-A noted R1's miconazole had been discontinued earlier that morning because she did not use it and would say she didn't want it at times. LPN-A stated she would document medications as not administered with note that drug/item was unavailable when a medication was not available and would then call the pharmacy. LPN-A confirmed she was R1's nurse and in charge of the medication cart with R1's medications. During observation, LPN-A searched R1's medications in the cart, house stock medications in the cart, R1's room, and the medication room for R1's miconazole cream. LPN-A confirmed she had not removed it from the cart for disposal and was not able to locate the medication. LPN-A confirmed this was a physician ordered medication and should be available, thought noted there had been a lack of supply previously. During an interview on 5/15/25 at 8:15 a.m., the director of nursing (DON) stated medications should be available for administration as ordered. If a medication was not available, the provider should be notified. If a medication was not available and staff failed to obtain a provider order to hold (not give) the medication, it would be a medication error. The DON stated she was not aware of R1's missed administrations of miconazole and tramadol. The DON stated if the tramadol was not given and the provider did not give an order to hold it, it would be considered a medication error. She stated she would expect R1's miconazole cream to be in stock and available for administration, would expect the provider to be notified if it was not, and would consider the missed administrations to be medication errors. The DON reviewed facility medication administration error reports and confirmed there were no medication errors reported for R1 between 3/1/25 and 5/13/25. During an interview on 5/15/25 at 10:46 a.m., the DON stated on 4/24/25 at 4:00 p.m. R1 received the last dose of her available tramadol, which was in 25 mg tablet form. On 4/24/25, staff were informed by the pharmacy that the 25 mg tablets would no longer be covered by insurance and got provider approval to change the prescription to half of a 50 mg tablet. R1 did not receive the medication again until 4/26/25 at 8:00 p.m. The DON stated she saw no indication the provider was notified of the ongoing lack of medication supply or missed administrations and would be processing this as a medication error. R2 R2's MDS dated [DATE], indicated he admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD). R2's care plan revised 2/6/25, identified R2's goal of care was comfort focused. Interventions included medications, treatments, and cares as ordered by primary physician and nurse practitioner. R2's physician orders included an order for albuterol sulfate aerosol inhaler 90 micrograms (mcg) per actuation with start date 12/3/24. Instructions were to inhale two puffs four times a day for COPD scheduled for administration at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's provider visit note dated 5/13/25, indicated he had a history of COPD with previous hospitalization s for pneumonia and COPD exacerbation. The note indicated R2's COPD was managed with medications including two puffs of an albuterol inhaler four times a day. R2's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled four daily administrations of albuterol. Documentation of the albuterol as not administered included: 4/2/25 at 4:00 p.m. and 8:00 p.m. with note drug/item unavailable Review of R2's progress notes did not identify documentation regarding availability of the albuterol inhaler, missed administrations, or related provider notifications. During an interview on 5/15/25 at 2:20 p.m., the DON confirmed documentation reflected two missed doses of albuterol on 4/2/25 with notes that it was unavailable. The DON stated she was not informed of this and did not see it in the facility's medication error reports. The DON stated she would expect it to be identified as a medication error and to be reported to the provider. The DON noted the medication was not administered in accordance with physician orders. Facility policy titled Administering Medications dated 8/31/23, included 2.) Medications are administered in accordance with the orders. 3.) Medications are administered within their prescribed time. 4.) The person preparing or administering the medication will contact the provider if there are questions or concerns regarding medication. 5.) With any irregularities, appropriate notifications will be completed for clarification. Facility policy titled Medication Error/Occurrence dated 8/31/23, included definition of a medication error as the preparation or administration of drugs or biologicals which is not in accordance with the attending providers' orders, manufacturer's specification or accepted standards and principles of the professional providing the services. Examples of medication errors included omissions. The policy included When an error is made in the preparation or administration of a drug or biological, the licensed nurse provides any necessary immediate care and notifies the attending provider and resident or resident representative when nursing or medical intervention, observation or treatment is indicated. Medication errors are tracked and trended for quality improvement purposes . Insignificant medication errors such as a missed vitamin C will be internally investigated and may not be reported as nursing or medical treatment is not necessary. Frequent nonsignificant errors will require additional process investigation and performance improvement interventions including notification to the medical director. The licensed nurse and/or nurse supervisor may notify the attending physician and resident/resident representative of medication errors as deemed appropriate . Documentation includes the date, time of the error or discovery of error, the resident's condition, including vital signs, notification of provider, medical orders and notification of the resident/resident representative.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on observation, interview, and document review the facility failed to provide adaptive eating utensils according to the care plan for 1 of 1 resident (R7) reviewed for nutrition. Findings include R7's face sheet dated 5/16/25, identified diagnosis of rheumatoid arthritis (a chronic inflammatory disorder affecting joints in hands or feet). R7's Minimum Data Set (MDS) dated [DATE], identified R7 was independent in eating and had intact cognition. R7's nutritional status focus care plan dated 5/7/25, identified a potential for altered nutrition related to rheumatoid arthritis, with an intervention of built-up utensils with all meals and culinary to provide. R7's nursing assistant care sheet dated 5/15/25, identified that R7 needed built-up utensils provided by the kitchen. R7's daily meal cards dated 5/15/25, identified R7 was to have built up utensils for all meals. R7's registered dietician progress note dated 3/6/25, identified R7 has continued to need built-up silverware to help with self-feeding related to rheumatoid arthritis. R7's grievance dated 3/21/25, identified R7 was not getting her built-up silverware with meals as ordered. An undated action identified culinary staff were educated on need to include built up silverware on meal tray. During an observation and interview on 5/15/25 at 12:54 p.m., R7 was in her room eating her meal of a pizza slice with a lettuce salad. R7 stated, How am I supposed to eat my salad without my built-up silverware. R7 was supposed to get them with all her meals, however had not received them in a long time. R7 stated her right hand did not work very well due to her rheumatoid arthritis and she had difficulty holding onto a regular utensils. R7 explained without having built up silverware she just uses her fingers to eat her salad. During an interview on 5/15/25 at 1:27 p.m., licensed practical nurse (LPN)-C confirmed R7 did not receive built-up silverware for her noon meal and was supposed to be having them placed on her tray for each meal. LPN-C further stated the dietary department has been educated on making sure they are place; however, it continues to be a problem. During an interview on 5/15/25 at 4:36 p.m., registered nurse regional director (RNRD) stated her expectation would be for dietary staff to follow the directions on the menu card and supply residents with the adaptive silverware if listed on the tray card for all meals. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Scope of Meal Service Policy undated, identified all culinary services personnel are responsible for the accuracy of tray assembly and all utensils are placed on the resident's tray. 51576

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to maintain a complete, accurately documented, and readily accessible medical record in accordance with accepted professional standards and practices for 2 of 3 residents (R2, R3) reviewed for documentation. Findings include: R2 R2's facesheet indicated he admitted to the facility on [DATE]. R2's electronic health record (EHR) was reviewed on 5/15/25. The EHR lacked any primary care provider (medical doctor, nurse practitioner, or physician assistant) visit notes from R2's current admission starting 12/3/24. During an interview on 5/15/25 at 10:46 a.m., the director of nursing (DON) confirmed there were no primary care provider visit notes in R2's EHR. R2's primary care provider visit notes were retrieved from the primary care provider's external medical records system by facility staff. Visit notes provided to surveyors absent from the facility's EHR included eight total visits from dates: 12/4/24, 12/17/24, 12/24/24, 1/7/25, 2/19/25, 3/25/25, 4/2/25, and 5/13/25. R3 R3's facesheet indicated she admitted to the facility on [DATE]. R3's EHR was reviewed on 5/14/25. The EHR lacked any primary care provider visit notes from R3's current admission starting 8/29/24. During an interview on 5/14/25 at 4:45 p.m., the DON confirmed there were no primary care provider visit notes in R2's EHR. R3's primary care provider visit notes were retrieved from the primary care provider's external medical records system by facility staff. Visit notes provided to surveyors absent from the facility's EHR included 17 total visits from dates: 9/3/24, 9/4/24, 9/10/24, 9/17/24, 9/24/24, 9/25/24, 10/8/24, 11/20/24, 11/26/24, 12/10/24, 12/24/24, 1/14/25, 1/29/25, 2/25/25, 3/5/25, 4/8/25, and 5/3/25. During an interview on 5/14/25 at 4:45 p.m., the DON stated primary care provider notes were handled by medical records who uploaded visit notes into resident EHRs. The DON stated she would expect to see provider notes uploaded in the EHR and it was important to have complete and accurate information about a resident. She would not consider a medical record complete and accurate without primary provider visit notes and this did not meet her expectations. The DON was not aware of a specific time frame within which notes should be uploaded but would guess within a month. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 5:22 p.m., the administrator stated she would expect provider notes to be in resident EHRs. The administrator noted this mattered because staff needed access to reference them and they were needed in case of an emergency. The administrator was not aware there were resident EHRs that contained no primary care provider notes. She would expect notes to be uploaded into EHRs as soon as they were received by the facility. Facility policy titled Charting and Documentation in the Medical Record dated 10/4/23, indicated the purpose was to ensure objective, accurate, timely and clinically complete information in the individual resident medical record. Information to be documented in the resident medical record included: Objective observations; Medications administered; Treatments or services performed; Changes in the resident's condition; Events, incidents or accidents involving the resident; Progress toward the care plan goals; other communication with resident representative. The policy indicated documentation in the medical record would be objective, complete, and accurate.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49338 Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded to excessively long call light response times by developing and implementing action plans for process improvement identified to be a current concern with past identified non compliancy. This had the potential to affect all 81 residents who resided in the facility. Findings include: The facility's QAPI Program Plan dated September 2024, identified the purpose of the quality program was to provide quality and performance excellence in care and service delivery. The plan included various areas of care and service with an ongoing process to select and monitor data. Quality focus areas identified by both the facility and community included regulatory compliance and customer concerns. Data was collected for regulatory compliance from CMS-2567 forms as it occurred and the threshold (level of performance that requires a reaction) was identified as compliance. Customer concern data was collected monthly from residents/families/guests with threshold of 90% or lower resolved in five days. The program's systematic analysis and systemic action included systematically analyzing underlying causes of systemic quality issues, developing/implementing quality improvement activities, and monitoring the effectiveness of actions. The Quality Council was noted to fulfill the role of the community's quality assessment and assurance committee and assumed responsibility for identifying and responding to quality deficiencies throughout the community. Additionally, the council developed and implemented corrective actions, monitored to ensure performance goals or targets were achieved, and revised corrective action when necessary. The facility's Quality Council meeting PowerPoint for March 2025 with corresponding meeting minute notes identified the council met on 3/25/25 to review data from February 2025. The PowerPoint included a slide titled MDH-Survey Plan of Correction/Audits which identified citation from annual survey with plan of correction dated 1/15/25 including F725 sufficient nursing staff. A slide titled Concerns identified there were zero concerns for the month related to call light issues. The PowerPoint and meeting notes lacked further information about the audits and did not identify the details of the data collected. There was no investigation or causal analysis of the data, specific related goal, identified action plan, or monitoring of effectiveness of the facility's related actions. The facility's Quality Council meeting PowerPoint for April 2025 with corresponding meeting minute notes identified the council met on 4/22/25 to review data from March 2025. The PowerPoint included a slide titled MDH-Survey Plan of Correction/Audits which identified citation from annual survey with plan of correction dated 1/15/25 including F725 sufficient nursing staff. A slide titled Concerns identified there were 19 total concerns for the month including 3 related to call light issues. The PowerPoint and meeting notes lacked further information about the audits or call light and did not identify the details of the data collected (audits completed and 3 concerns). There was no investigation or causal analysis of the data, specific related goal, identified action plan, or monitoring of effectiveness of the facility's related actions. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's grievance log dated 2/20/25 through 5/12/25, included call light grievances related to staff response times. Grievances included: - On 3/25/25, a resident expressed concern that he put his call light on, waited 30 minutes with no response, and then went to the nursing station to ask staff for assistance. - On 4/1/25, a resident stated at night she had to wait over an hour for someone to answer her call light. - On 4/14/25, a resident stated when she put her call light on for toileting it was not answered fast enough, and she had to go in her brief. - On 4/14/25, a resident stated he put his call light on at 2:00 am and a staff member answered the light, turned the light off, left the room, and did not address his needs. - On 4/26/25, a resident reported she put her call light on and waited over an hour for staff to respond. Facility audit sheets titled F725 Sufficient Nursing Staff: Call Light Times included columns titled date, resident, shift being audited, were call lights answered timely, does resident have any concerns with call light times, and comments. Completed audit sheets were dated from 2/25/25 through 5/7/25. During an interview on 5/14/25 at 5:22 p.m., the administrator stated each nurse manager had been completing audits each week on a variety of shift. The administrator stated currently one resident and one shift was being audited each week, and the resident and shift had been picked at random. The administrator stated she had not heard of any concerns identified on the audits but had reviewed call light logs requested by surveyors and the data reflected in the call light logs did not align with what was recorded on the audit sheets. The administrator stated no specific direction was given to nurse managers when completing the audits, such as what constituted answering a call light timely, and they just followed the prompts in the column titles. She noted the QAPI committee met monthly and reviewed reportable incidents from the prior month, current plans of correction being worked though, admission data, quality improvement program data, return to hospital data, medication errors, skin issues, falls, behavior management, concerns from the prior month, nutrition and weight data, human resources data, and anything else relevant at the time. The administrator stated call light logs have not been included in QAPI and noted they were listed under the current audits the facility was doing and there hasn't been concerns in the actual audits. The administrator stated call lights had not been identified as on ongoing concern. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/15/25 at 8:15 a.m., the director of nursing (DON) stated she was aware call lights were an ongoing problem because of concerns and reports from residents. The DON stated data regarding call light times was monitored through the audits and resident concerns, like grievances filed. The DON reviewed the facility's call light logs dated 2/25/25 through 5/7/25. She identified some audits were marked see attached and did not specify if the light was answered timely or the resident had concerns, some audits stated lights were answered timely but included call light logs with times that did not meet her expectations for timeliness, and some audits were not completed fully. The DON stated the audits were not complete or accurate, did not specify what constituted timeliness, and did not include analysis of the data. The DON was unable to articulate how the facility was analyzing data and monitoring the call light times when the data collected was not complete or accurate and stated we weren't doing that effectively. She noted call light data came from audits and grievances and would be analyzed prior to and reviewed at QAPI meetings. She confirmed the QAPI meeting slide for plans of correction did not include data. After reviewing the call light audit sheets, she stated the data in the audits identified ongoing concerns and noted I don't see inclusion or analysis of the data or development of an improvement plan in the QAPI committee meetings. She further noted there was no analysis of the causal factor of action plan that I'm aware of and identified the administrator as the person who had been more involved and would know more. During and interview on 5/15/25 at 3:39 p.m., the administrator stated call lights were identified as an issue and the facility was cited for this in January. The plan to monitor and ensure compliance was nurse managers completing call light audits weekly, though she stated the audits were not complete or accurate. The administrator stated audits were analyzed by the nurse managers completing them, the DON, and herself and they did not identify the call light times as continued issue through the audits but they should have. She stated call light time data had not been analyzed in QAPI and a causal analysis had not been completed. The administrator stated the QAPI committee meeting showed the audits were being done and identified the number of related grievances, but we need to do more a deep dive into the why's behind them. She confirmed there was no action plan for process improvement based on the data and no measurable goal for call light times. She stated, the goal was 15 minutes, but it is not identified. Facility policy titled Call Lights - Call System Activation and Response dated 5/28/24, included Call light response times are reviewed as part of the QAPI program. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy titled Quality Council (Quality Assessment and Assurance Committee) undated, indicated the facility had a Quality Council. The Quality Council assumes responsibility and oversight for services related to resident safety, health outcomes, resident autonomy, choice, quality of care, as well as customer satisfaction, regulatory compliance, and related performance improvement. The community will develop a plan to promote excellence in quality of care, quality of life, resident choice and person directed care. To accomplish this all employees are empowered to participate in ongoing QAPI efforts which support our mission. The Quality Council will collect and utilize data related to the unique characteristics and needs of the patients, focusing on high risk, problem prone, and high-volume areas to develop their annual QAPI plan. The Quality Council serves as the Community's Quality Assessment and Assurance (QAA) Committee with oversight of the Quality Assurance and Process Improvement (QAPI) program. Procedure included, The Quality Assessment and Assurance committee Plan describes the process for identifying and correcting quality deficiencies and includes: a) Tracking and measuring performance; b) Establishing goals and thresholds for performance improvement; c) Evaluation of the care and services provided; d) Identifying and prioritizing quality deficiencies and opportunities for improvement; e) Systematically analyzing underlying causes of systemic quality deficiencies; f) Developing and implementing corrective action or performance improvement activities; g) Monitoring and/or evaluating the effectiveness of corrective action and performance improvement activities and revising as indicated; h) The QAA plan will be reviewed annually and with any significant change to the community.