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	03/05/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to maintain a clean, homelike environment for 2 of 2 residents (R45, R2) who received nutrition via tube feeding.Findings include: R45 R45's admission Minimum Data Set (MDS) dated [DATE], indicated R45's cognition could not be assessed, was dependent on staff for all activities of daily living (ADLs), and required nutrition through a feeding tube. R45's diagnosis included traumatic brain injury (a condition resulting from an injury to the head causing disruption of normal brain function and can affect cognition, speech, and physical abilities). R45's care plan dated 10/3/25, indicated potential for altered nutritional/hydration status related to tube feeding. R45's care plan instructed staff to administer tube feeding with water flushes per provider order. R45's care plan further indicated R45 also received an oral diet with modified textures for pleasure or comfort. R45's provider order dated 3/2/26, indicated, Tube Feeding: Continue with EN [enteral nutrition] support via PEG [percutaneous endoscopic gastrostomy – a tube through the abdomen into the stomach]. Current EN prescription is Osmolite 1.2 at 55 milliliters (ml)l/hour. Water flush of 65 ml/hr. Tube feeding administered continuously using enteral pump. During observation on 3/2/26 at 6:44 p.m., R44 had a tube feeding formula hanging. The tube feeding was attached to R45 via a PEG tube and running. The base of the pole that held the bag of tube feeding formula and water flush, as well as the enteral feeding pump had numerous spots of a dried beige substance which appeared to be tube feeding formula spillage. During observation on 3/3/26 at 10:06 a.m., R44 was in bed with his tube feeding attached and running and still had numerous spots of a dried, beige colored substance on the base of the tube feeding pole. During observation on 3/3/26 at 10:45 a.m., housekeeper (H)-A was in R45's room cleaning. During interview on 3/3/26 at 10:48 a.m., H-A stated she had finished cleaning R45's room. H-A reentered R45's room and confirmed R45's tube feeding pole had a copious amount of tube feeding formula spilled on the base. H-A stated they did not think the tube feeding poles that were in use were her responsibility to clean. H-A stated she would move the pole and clean the floor under the pole, when necessary, but would not touch the pole otherwise while the feeding was running and attached (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the resident. H-A further stated, I don't know who is supposed to clean it. R2 R2's quarterly MDS dated [DATE], indicated R2 had severe cognitive impairment, impairment of upper and lower extremities, and was dependent on staff for bed mobility, and transfers. It also indicated R2 required EN and had diagnoses of stroke with hemiplegia (paralysis to one side of the body) and severe protein-calorie malnutrition. R2's care plan dated 2/1/26, indicated potential for altered nutritional/hydration status related to tube feeding. R2's care plan instructed staff to administer tube feeding with water flushes per provider order. R2's care plan further indicated R2 also received an oral diet with modified textures for pleasure or comfort. R2's physician order dated 2/27/26, indicated, Tube feeding continue with EN support via G- tube. Current EN prescription was Isosource 1.5, 45ml/hr. Water flush of 25ml/hr. Tube feeding administered continuously using enteral pump. During observation on 3/2/26 at 4:49 p.m., R2 had tube feeding formula hanging, attached to R2 via G-tube and running. The base and the pole that held the bag of tube feeding formula and water flush, as well as the enteral feeding pump had copious amount of light brown drips and large brown spots of dried liquid on it. During observation on 3/3/26 at 11:20 a.m., R2 was in bed with his tube feeding attached and running and still had copious amounts of dried beige colored substance on the base of the tube feeding pole. During interview on 3/3/26 at 11:39 a.m., housekeeper (H)-B stated they cleaned R2 room, however, housekeeping was not responsible for cleaning R2's tube feed pole or machine. H-B verified there was a lot of brown dried liquid all over the pole and the base of the pole. The housekeeping cleaning list did not have tube feeding pole listed to clean it. During interview on 3/3/26 at 11:53 a.m., registered nurse (RN)-F stated there was a large amount of dried formula on the machine, pole and base. Furthermore, RN-F had administered R2's medication this am, however, did not clean the pole or machine. During interview on 3/3/26 at 11:35 a.m., RN-A stated they would expect nursing to wipe up any formula at the time of the spill and that housekeeping could also share the responsibility if a dirty pole was seen when cleaning the resident room. RN-A further stated they would expect residents to have a clean, homelike environment. During interview on 3/3/26 at 3:37 p.m., director of nursing (DON) stated nursing should clean the tube feeding poles when a spill occurs, and that housekeeping could also clean the poles as needed. DON stated would expect residents' dignity to be considered and should and a clean homelike environment provided. Facility policy titled Monitoring Residents Receiving Enteral Feedings dated August 2019, directed the nursing staff to be responsible for the administration of enteral feedings and all feeding equipment. Facility policy titled Resident Care Equipment dated 1/2024, directed staff to ensure IV poles were cleaned when soiled by either housekeeping or nursing.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an antipsychotic medication (medication that works by changing the effects of chemicals in the brain) had a qualifying diagnosis to support its use for 1 of 5 residents (R8) reviewed who required antipsychotic medicationsFindings include:R8's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment. R8 did not hallucinate, have delusions, behaviors, wander or reject care during the assessment period. R8 took an antipsychotic medication in the last seven days, and an indication was noted.R8's psychotropic drug use care plan dated 2/27/26, identified psychotropic medication was in use, to administer medications per MD (medical doctor) order, monthly medication record review by pharmacist, and monitor for target behaviors daily.R8's provider orders dated 9/17/25, identified Risperdal (risperidone, an antipsychotic medication) two milligrams (mg) tablets by mouth at bedtime for a diagnosis of major depressive disorder, single episode, mild.R8's available Associated Clinic of Psychiatry (ACP) visits dated 10/28/25, 10/31/25, 11/20/25, 12/1/25, 1/9/26, and 1/23/26, lacked a diagnosis associated with Risperdal use.R8's Consultant Pharmacist (CP) recommendation to physician dated 8/23/25, and 1/19/26, identified R8 received an antipsychotic medication Risperdal 2 mg at bedtime for MDD (major depressive disorder, mild) and a qualifying diagnosis to support its use was not documented. Per CMS (Center for Medicaid and Medicare Services) guidelines and DSM-5 (Diagnostic and Statistical Manual of Mental Disorder) diagnostic criteria, antipsychotic medications are generally appropriate only when used to treat the following conditions:Schizophrenia spectrum disorders (e.g. schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder)Bipolar I or II disorders with manic, mixed or psychotic features.Major depressive disorder with psychotic featuresRefractory major depressionBrief psychotic disorderPsychotic disorder due to another medical condition (e.g. delirium with psychotic features)Other specified or unspecified schizophrenia spectrum and psychotic disorders.During an interview on 3/5/26 at 12:15 p.m., the director of nursing (DON) stated R8's diagnosis should come from ACP psychiatry and not the primary care provider. The DON stated the facility policy was to print the recommendation and follow up right away by giving the recommendation to the provider. The DON stated there was no documentation the facility followed up with the ACP provider to obtain a qualifying diagnosis. The DON did not identify what types of qualifying diagnoses applied to antipsychotic medications. During an email on 3/5/26 at 1:09 p.m., the CP identified she was not available for phone calls. The CP's email response identified R8's' psychiatric services were managed by ACP. In situations where outside psychiatric providers oversee psychotropic management, the facility appropriately forwards consultant pharmacist recommendations to the prescribing provider by fax for review. The facility's Psychotropic Medication Use policy dated 9/7/23, directed the DON to implement the policy to ensure psychotropic medications were ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record. Additionally, the nursing associates would collaborate with the medical providers to ensure the lowest possible dosage was given for the shortest period. The policy lacked the process to review qualifying diagnoses for antipsychotic medications.

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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** Based on observation, interview and document review the facility failed to ensure the manufacturer's recommended sling size was used for 1 of 1 resident (R79) reviewed for mechanical lift transfers. Findings include: R79's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no behaviors. R79 had impairment to upper and lower extremities, was dependent staff for bed to chair transfers and had a diagnosis of traumatic brain dysfunction. R79 had no falls since the prior assessment.R79's admission Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 9/17/25, identified the CAA triggered due to assistance required in ADLs, impaired balance and transition during transfers and functional impairment in activity. Contributing factors included generalized weakness.R79's ADL care plan dated 9/11/25, identified two staff assist was required with full body mechanical lift with a sling size of medium.R79's Safe Lifting and Movement assessment dated [DATE], identified he could not stand for eight seconds without any devices, had unpredictable behavior changes frequently and was unable to follow simple commands. R79 required two person transfers with full body mechanical lift and R79's height was five feet seven inches and most recent weight was 155 pounds. During an observation and interview on 3/2/26 at 3:24 p.m., nursing assistant (NA)-A positioned an EZ Lift brand full body sling with maroon straps under R79 while he sat in his wheelchair. NA-A had not looked at the sling label for size, and positioned the sling behind R79's back, brought the leg straps under R79's legs, crossed the straps, connected the sling to EZ Lift model 798 (full body mechanical lift) and connected the longer lower loop to the EZ Lift hooks. NA-B connected the upper loops using the lower strap to the EZ lift hooks. NA-A raised R79 in the sling out of R79's wheelchair, pushed the lift over to the bed, lowered R79 to the bed and NA-A and NA-B lowered the sling to the bed and removed the sling from under R79. During the transfer R79's body was tilted to the right, instead of straight up and down, and his left hip and buttocks hung down through the sling seat opening area. When asked what sling size was used, NA-A picked up the sling that was removed and read the label which read size large. NA-A stated he should have checked the sling size before completing the transfer. NA-A removed the sling from R79's room as it was soiled.During a follow up interview on 3/2/26 at 5:38 p.m., NA-B stated staff should reference the care card for mechanical lift sling sizes. NA-B presented the care card which specified a medium sling should have been used. NA-B stated sometimes if a resident had a shower and the sling got wet, staff would have to use what was available. NA-B confirmed she was with Na-A during the transfer, and the sling size was not checked.During an interview on 3/2/26 at 5:43 p.m., registered nurse (RN)-B stated mechanical lift sling size was the responsibility of the managers and the staff should reference the resident care cards. RN-B presented R79's care card which identified he needed a medium body sling. RN-B stated she would look for a medium sling, since NA-A brought the sling to the laundry and no sling was currently available.During an interview on 3/4/26 at 2:38 p.m., the director of nursing (DON) stated therapy would establish sling size for residents and communicate with the managers so the care cards could be updated. The purpose of appropriately sizing a sling was to prevent accidents due to unsafe equipment.During an interview on 3/5/26 at 11:53 a.m., the physical therapist (PT) verified R79 should use a medium size sling to ensure transfers are stable.The EZ Way Sling Size Chart (form #2-150) dated 9/13/24, identified a large sling (burgundy straps) should be used for resident weight of 190 to 330 pounds and maximum distance from tailbone to base of neck of 26 inches, and medium sling size (beige straps) should be used for resident weight of 90 to 220 pounds and maximum distance from tailbone to base of neck 24 inches.The facility's undated policy titled Using a Mechanical Lift, identified a resident needed to be measured for proper sling size and purpose according to manufacturer's instructions and to double check the sling and machine's weight limit against the resident's weight. After placing the sling under the resident, visually check the size to ensure it is not too large or too small.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure administration of tube feeding formula according to provider orders for 1 of 1 resident (R45) reviewed for tube feeding. Findings include:R45's admission Minimum Data Set (MDS) dated [DATE], indicated R45's cognition could not be assessed, was dependent on staff for all activities of daily living (ADLs), and required nutrition through a feeding tube. R45's diagnosis included traumatic brain injury (a condition resulting from an injury to the head causing disruption of normal brain function and can affect cognition, speech, and physical abilities). R45's care plan dated 10/3/25, indicated potential for altered nutritional/hydration status related to tube feeding. R45's care plan instructed staff to administer tube feeding with water flushes per provider order. R45's care plan further indicated R45 also received an oral diet with modified textures for pleasure or comfort.R45's nutrition progress note by registered dietician (RD) dated 3/2/26 at 2:54 p.m., indicated R45 experienced a weight gain since admission of 15 pounds which was contributed to good oral intake combined with tube feeding formula running at 75 milliliters an hour (ml/hr) continuously for 24 hours with water flushes of 65 ml/hr over 24 hours. R45's progress note indicated RD ordered a reduction in the tube feeding rate to 55 ml/hr and continued the water flushes as previously ordered.R45's provider order dated 3/2/26, indicated, Tube Feeding: Continue with EN [enteral nutrition] support via PEG [percutaneous endoscopic gastrostomy - a tube through the abdomen into the stomach]. Current EN prescription is Osmolite 1.2 at 55 ml/hour. Water flush of 65 ml/hr. Tube feeding administered continuously using enteral pump.R45's March 2026, medication administration record (MAR) printed on 3/3/26 at 10:20 a.m., indicated R45's tube feeding of 55 ml/hr with water flushes at 65 ml/hr was signed off as completed on 3/2/26 shift 2 (evenings) and shift 3 (nights), and 3/3/26 shift 1 (days). R45's MAR further indicated the tube feeding at 70 ml/hr with 65 ml/hr water flush was not given on 3/2/26 at 3:40 p.m., due to being discontinued.During observation on 3/2/26 at 6:44 p.m., R45's tube feeding was running at 70 ml/hr.During observation 3/3/26 at 10:06 a.m., R45's tube feeding was running at 70 ml/hr. The tube feeding formula was labelled 3/3/26 1:30 a.m.During interview on 3/3/26 at 10:32 a.m., licensed practical nurse (LPN)-A stated when a resident received continuous tube feeding and water flushes, the formula and water bags were changed when they ran out. LPN-A stated R45's tube feeding was running at 70 ml/hr as it had been for quite some time. LPN-A stated they just replaced the bags as needed and did not adjust the rate since the rate never changed. LPN-A looked in R45's electronic medical record (EMAR) and verbally verified R45 had a new order for his tube feeding to run at 55 ml/hr instead of 70 ml/hr. LPN-A entered R45's room and confirmed R45's tube feeding was running at 70 ml/hr and it was not running as ordered. LPN-A stated when a new order was placed, a second nurse had to verify the order in the EMAR prior to the first administration of the new order. During interview on 3/3/26 at 2:40 p.m., LPN-B stated he verified R45's new order of 55 ml/hr in the EMAR on 3/2/26 at the start of the evening shift but did not hang a new bag on his shift. LPN-B stated he signed off the tube feeding in the EMAR for his shift to indicate the rate had been confirmed but stated he did not visually confirm the rate at which R45's tube feeding was running. LPN-B could not explain why he was not aware of the new rate even though he had verified the new order in the EMAR.During interview on 3/3/26 at 2:47 p.m., registered nurse (RN)-A expected nurses to follow orders as written and would not expect nurses to sign off medication administration or treatments if not actually completed. RN-A stated orders should be verified by a second nurse. The nurse who verified the order would sign off the order as verified prior to any administration or treatment.During interview on 3/3/26 at 3:37 p.m., director of nursing (DON) expected nursing staff to follow provider orders as written and not sign off items on the MAR or TAR if not actually completed. During interview on 3/4/26 at 1:54 p.m., RD stated would expect orders to be followed as entered. RD stated (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's tube feeding rate had been changed on 3/2/26, to a lower rate due to his weight gain and would expect nurses to have changed the rate with the most recent administration.A facility policy titled Monitoring Residents Receiving Enteral Feedings dated August 2019, indicated residents who receive enteral feeding will receive appropriate treatment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure respiratory equipment was properly maintained for 1 of 1 resident (R44) reviewed for respiratory care. Findings include:R44's admission Minimum Data Set (MDS) dated [DATE], indicated R44 had intact cognition, required partial/moderate assistance with most activities of daily living (ADLs), and required oxygen therapy while a resident. R44's diagnoses included chronic respiratory failure, congestive heart failure (CHF) and dependence on supplemental oxygen. R44's care plan dated 1/15/26, indicated R44 required special treatments including oxygen therapy. R44's treatment administration record (TAR) dated 2/15/26 through 3/2/26, indicated, Change humidifying jar [bubbler] weekly.once a day on Sun. The TAR indicated the task was signed off as completed on 2/15/26, 2/22/26, and 3/1/26. During observation on 3/2/26 at 1:35 p.m., R44 was in her room in a wheelchair with oxygen administered via nasal canula at 2 liters per minute. The undated oxygen tubing was attached and running through a bubbler. The bubbler was labeled, 2/15 JMD. During interview on 3/2/26 at 1:51 p.m., licensed practical nurse (LPN)-C stated oxygen tubing and bubbler were changed once a week by the nurse. LPN-C stated she forgot to change R44's bubbler yesterday (3/1/26). Further, she verified she should not have signed it off as being completed since she did not complete the task outlined on the TAR. LPN-C confirmed R44's oxygen tubing was not dated, and the bubbler was dated 2/15. LPN-C could not confirm when the tubing had last been changed and could not explain why the bubbler was signed off as changed on 2/22/26 and still had the 2/15 date on it. During interview on 3/3/26 at 2:47 p.m., registered nurse (RN)-A expected nurses to follow orders as written and would not expect nurses to sign off medication administrations or treatments if they were not actually completed. RN-A further stated R44's oxygen tubing and bubbler should be changed weekly to prevent any respiratory infections. During interview on 3/3/26 at 3:37 p.m., director of nursing (DON) stated staff were expected to follow provider orders as written and not sign off items on the medication administration record (MAR) or TAR if not actually completed. Facility policy Cleaning of Oxygen Equipment dated June 2017, identified purpose to reduce the risk of infections and directed staff to replace oxygen tubing and humidifier bottle once a week and to use tape to place date and initials on tubing and bottle when replaced.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure new medication orders were transcribed correctly to ensure accurate medication administration for 1 of 1 resident (R79) who was reviewed for recent medication changes. Findings include:R79's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no behaviors. R79 had impairment to upper and lower extremities, was dependent on staff for bed to chair transfers and had a diagnosis of traumatic brain dysfunction.R79's Cognitive loss/Dementia care plan dated 1/20/26, identified a diagnosis of cognitive loss from a traumatic brain dysfunction. R79 would receive services and assistance needed specific to his cognitive function. R79's family member assisted with decision making.R79's hospital After Visit Summary (AVS) dated 2/27/26 at 9:53 p.m., identified he was seen due to redness of skin, seizure like activity and fever. Instructions included to stop taking lacosamide which is an anti-seizure medication, and to start taking levetiracetam (Keppra) which is a different antiseizure medication; take 500 milligrams (mg) by mouth two times a day for 14 days.R79's undated active orders included:-Start date of 2/25/25, lacosamide 100 mg tablet by mouth two times a day.-Start date of 2/28/26, levetiracetam 500 mg tablet by mouth two times a day for 14 days.R79's medication administration record dated 2/25/26 through 3/2/26, identified lacosamide 100 mg by mouth twice daily was documented as held due to R79's emergency department (ED) visit on the evening of 2/27/26, refused the morning of 2/28/26, on hold per report the evening of 2/28/26, refused the morning of 3/1/26, and on hold the evening of 3/1/26. The medication was administered the morning of 3/2/26. The medication was not discontinued from R79's medical record on 2/27/26, as ordered in the AVS.During an interview on 3/2/26 at 12:16 p.m., R79's family member (FM)-A stated last week R79 had what looked like a seizure, went to the hospital to be evaluated and was started on lacosamide (an antiseizure medication). A couple of days later R79 went to the hospital again with a suspected reaction to the lacosamide which included a new rash and lip swelling. The hospital doctor discontinued the lacosamide and started a new anti-seizure medication and R79 returned to the facility.During an observation and interview on 3/2/26 at 3:45 p.m., licensed practical nurse (LPN)-G and registered nurse (RN)-E entered R79's room with one yellow shaped pill and stated it was R79's lacosamide. FM-A stated the lacosamide was discontinued and showed R79's AVS dated 2/27/26, which identified the medication was discontinued. LPN-G and RN-E left R79's room and went to the nurse's cart. At the cart, the lacosamide 100 mg was verified as the pill brought into R79's room. FM-A brought the AVS up to the nurse's cart and LPN-G and RN-E verified the AVS FM-A had, matched the AVS which was uploaded in R79's electronic medical record (EMR). FM-A stated there were no signs of current allergy.During a follow up interview on 3/2/26 at 3:55 p.m., registered nurse (RN)-E verified lacosamide was an active order and the previous nurse should have discontinued the medication from the system and not documented as refused or held. RN-E stated he called R79's primary care provider and was awaiting a return call.During an interview on 3/2/26 at 4:12 p.m., RN-B stated after hours, and on weekends, new orders were to be transcribed into the medical record by a nurse and verified by another nurse. RN-B reviewed R79's AVS and stated the order should have been discontinued from R79's EMR. RN-B stated the interdisciplinary team reviewed R79's emergency room visit but had not looked to see if the new orders had been implemented correctly.During an interview on 3/3/26 at 2:58 p.m., LPN-E stated she worked with R79 on the weekend. On weekends and after hours the nurse on duty would update orders into the EMR and a second nurse would verify the orders. LPN-E stated she held the medication on the weekend due to family request. LPN-E stated the medication should have been discontinued from the EMR once the new orders were received. During an interview on 3/4/26 at 9:19 a.m., the nurse practitioner (NP) stated she was updated on 3/2/26, about the medication transcription error and that R79 received an extra dose after the lacosamide was discontinued. The (continued on next page)

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Cerenity Care Center on Humboldt	512 Humboldt Avenue Saint Paul, MN 55107

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NP would have expected the medication to be transcribed as ordered. Additionally, the transcription error was not serious because after the medication was discontinued, only one extra dose was administered. NP-A stated she was unsure of lacosamide being a true allergy at this time. During an interview on 3/4/26 at 2:58 p.m., RN-C stated she worked on 2/27/26, in the evening when R79 returned from the emergency department. RN-C stated she entered the new order for Keppra into R79's EMR, however did not see the new order to stop the lacosamide.During an interview on 3/5/26 at 12:22 p.m., the director of nursing (DON) stated he expected two nurses to verify new medication orders for accuracy. New orders for a resident should be reviewed and implemented as soon as possible. The DON stated the order was missed on the AVS at the time of R79's return, and subsequent nurses had not reviewed the original AVS.A medication transcription policy was not obtained on survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were followed up timely for 1 of 5 residents (R8) reviewed for unnecessary medications.Findings include:R8's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment. R8 did not hallucinate, have delusions, behaviors, wander or reject care during the assessment period. R8 took an antipsychotic medication (medication that works by changing the effects of chemicals in the brain) in the last seven days, and an indication was noted.R8's psychotropic drug use care plan dated 2/27/26, identified psychotropic medication was in use, to administer medications per MD (medical doctor) order, monthly medication record review by pharmacist, and monitor for target behaviors daily.R8's prescription orders dated 9/17/25, identified Risperdal (risperidone. antipsychotic medication) two milligrams (mg) tablets by mouth at bedtime for a diagnosis of major depressive disorder, single episode, mild.R8's available Associated Clinic of Psychiatry (ACP) visits dated 10/28/25, 10/31/25, 11/20/25, 12/1/25, 1/9/26, and 1/23/26 lacked a diagnosis for Risperdal.R8's Consultant Pharmacist (CP) Recommendation to Physician dated 8/23/25, and 1/19/26, identified R8 received an antipsychotic medication Risperdal (risperidone) 2 mg at bedtime (HS), for MDD (major depressive disorder, mild) and a qualifying diagnosis to support its use was not documented. Per CMS (Centers for Medicaid and Medicare Services) guidelines and DSM-5 (Diagnostic and Statistical Manual of Mental Disorder) diagnostic criteria, antipsychotic medications are generally appropriate only when used to treat the following conditions:Schizophrenia spectrum disorders (e.g. schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder)Bipolar I or II disorders with manic, mixed or psychotic features.Major depressive disorder with psychotic featuresRefractory major depressionBrief psychotic disorderPsychotic disorder due to another medical condition (e.g. delirium with psychotic features)Other specified or unspecified schizophrenia spectrum and psychotic disorders.R8's electronic medical record lacked indication the facility had followed up on the CP recommendations from 8/23/25 or 1/19/26. Follow up for R8's CP recommendations for 8/23/25 and 1/19/26 were requested, however were not received.The CP issued the recommendations first on 8/23/25, and again on 1/19/26, and it was still not addressed 3/5/26, which was 6 months and 10 days after the initial recommendation.During an interview on 3/5/26 at 12:15 p.m., the director of nursing (DON) stated R8's diagnosis should come from ACP psychiatry and not the primary care provider. Additionally, CP recommendations should be followed upon monthly unless otherwise indicated by the CP. The DON stated the facility policy was to print the recommendation and follow up right away by giving the recommendation to the provider. The DON stated there was no documentation the facility attempted to follow up with the ACP provider to obtain a qualifying diagnosis. During an email on 3/4/26 at 2:33 p.m., the CP identified she was not available for phone calls. The expectation was that clinical staff respond in a timely manner either accepting the recommendation or providing patient specific clinical rationale as to why the recommendation was declined.Communication via email on 3/5/26 at 1:09 p.m., the CP identified she was not available for phone calls. The email response identified timely follow-up and resolution of CP recommendations were routinely emphasized through ongoing collaboration with facility leadership. During Quality Assurance and Performance Improvement (QAPI) meetings and routine discussions with the DON, the importance of reviewing and responding to recommendations in a timely manner was reinforced. For R8, the initial recommendation was made in August. Follow-up communication was provided via email to the DON in October, and the recommendation was re-sent in January to ensure continued review. The residents' psychiatric services were managed by ACP. In situations where outside psychiatric providers oversaw psychotropic management, the facility was expected to forward the recommendations to the prescribing provider by fax for review. When monitoring response (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timelines, the CP took these additional communication steps and the involvement of outside specialty providers into consideration, while continuing to follow up as needed to support appropriate medication management.The facility's Psychotropic Medication Use policy dated 9/7/23, identified the DON was responsible for implementation of this policy. Psychotropic medications were ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record. Additionally, the nursing associates would collaborate with the medical providers to ensure the lowest possible dosage was given for the shortest period. The policy lacked the process to review qualifying diagnoses for antipsychotic medications.The facility's Consultant Pharmacist Services Provider Requirements dated 12/17, indicated a written or electronic report of findings and recommendations would be completed monthly and the facility had a process to ensure the findings were acted upon.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to implement enhanced barrier precautions (EBP) for 2 of 2 residents (R19 and R2) observed for EBP.Findings include: R19 R19's comprehensive Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, no behaviors or rejection of care. R19 required substantial/maximal assistance with eating, bathing and dressing. Diagnoses included orthopedic aftercare. R19 had two unhealed pressure ulcers classified as unstageable (wounds where the extent of tissue damage cannot be identified) and present upon admission. R19's admission pressure ulcer Care Area Assessment (CAA) dated 12/17/25, triggered due to actual pressure ulcers. Care plan interventions would be initiated to improve current activities of daily living status and functional ability. R19's care plan dated 2/14/26, identified he was on EBP for osteomyelitis (bone infection) and presence of a wound. Interventions included implement EBP according to facility protocol. Clear signage would be posted on the door to indicate the presence of personal protective equipment (PPE) requirements. Staff were directed to apply gloves and gown prior to high-contact care activities. R19's medication orders dated 3/2/26 through 3/29/26, identified give one-gram meropenem (antibiotic medication) intravenous (IV) solution twice daily for a diagnosis of osteomyelitis. During an observation and interview on 3/4/26 at 8:29 a.m., licensed practical nurse (LPN)-H prepared R19's 8:00 a.m., dosage of IV meropenem while LPN-C observed. LPN-H stated R19 had a peripherally inserted central catheter (PICC); a type of central line which delivers medication via IV. During an observation and interview on 3/4/26 at 8:45 a.m., R19's room door had a sign directing EBP were in place. The EBP door sign identified: Wear gloves and a gown for high-contact resident care activities such as device care or use of a central line. A PPE bin was located outside the door containing gloves and gowns. LPN-H donned (put on) gloves from the PPE bin, but no gown, and entered R19's room. LPN-H raised R19's head of bed, set a pill cup on the bedside table, administered pills and then the inhaler. LPN-H then doffed (removed) the used gloves and donned new gloves, cleaned R19's PICC line port with an alcohol wipe, and flushed the PICC line with 10 milliliters(mL) of normal saline. LPN-B was present in the room observing. At 8:56 a.m., LPN-H hung R19's meropenem on the IV pole, and the surveyor stopped the procedure. When asked if any other PPE was required for PICC line care, LPN-B and LPN-H reviewed the sign on the room door which identified a gown and gloves should be worn during PICC line care. LPN-B asked LPN-H to don PPE. LPN-H removed his gloves, exited the room, used an alcohol-based hand rub, donned a gown and gloves and reentered the room to administer R19's IV antibiotic as ordered. At 9:05 a.m., LPN-H doffed his PPE, used an alcohol-based hand rub and exited R19's room. LPN-H stated he did not notice the sign on the door with the PPE requirements but had received training upon hire on the process. R2 R2's quarterly MDS dated [DATE], indicated R2 had severe cognitive impairment, impairment of upper (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and lower extremities, and was dependent on staff for total body care, bed mobility, and transfers. It also indicated R2 had enteral feeding (administer liquid nutrition and medication in a tube in abdomen), diagnoses of stroke with hemiplegia (paralysis to one side of the body) and severe protein-calorie malnutrition. R2's physician orders dated 8/4/25, indicated R2 required care for feeding tube: wash around tube daily and as needed, with warm water and cloth, apply sterile split gauze around site, and secure in place as needed. R2 further required EBP to be implemented for cares of R2. R2's care plan dated 8/10/25, indicated R2 had an enteral nutrition via a feeding tube. Interventions included EBP according to facility protocol. Post clear signage on the door or wall outside of resident room and required personal protective equipment. During observation on 3/4/26 at 7:55 a.m., R2's door sign stated enhanced barrier precautions and directed staff to use gown and gloves during high contact cares. Outside of R2's room was a cart with PPE that included gowns and gloves. Registered nurse (RN)-D completed hand hygiene, donned gloves and entered R2's room without donning a gown. RN-D disconnected R2's tube feeding, administered medications and flushes and reconnected R2's tube feeding. RN-D then took off the old dressing from the feeding tube site, cleaned the tube site and placed a new dressing. During observation and interview on 3/4/26 at 8:13 a.m., nursing assistant (NA)-D and NA-F had entered R2's room to assist R2 with personal cares. Without gowns on, NA-D and NA-F rolled R2 side to side and proceeded to change R2's linen and soiled brief. NA-D stated it was not necessary to wear EBP such as a gown during personal cares with R2. After cares were completed, NA-D verified R2 had a EBP sign on door with PPE equipment cart outside of the room directing them to wear gown and gloves with close contact cares. During interview on 3/4/26 at 1:43 p.m., NA-F stated EBP not necessary unless touching or doing direct cares with R2's feeding tube. A gown wasn't necessary to wear, but gloves were when providing personal cares with R2. During interview on 3/4/26 at 1:58 p.m., RN-D stated PPE was to be worn according to the signage on residents' door. EBP could include a mask, gown and gloves. EBP was used in cares that included dressing changes, tube feedings and personal care. RN-D verified she did not wear a gown when completing R2's tube feeding cares and medication administration. Furthermore, EBP was used to decrease risk of infections. During interview on 3/5/26 at 11:33a.m., infection preventionist (IP) stated they expected staff to don gown and gloves for any cares/contact with residents who required EBP. This included IV medication administration, personal cares and tube feeding cares. During interview on 3/5/26 at 1:31 p.m., director of nursing (DON) stated staff were expected to wear proper PPE when doing personal or direct cares with residents on EBP. They were to wear gloves, gown and mask. The information was on the sign on the residents' door. EBP was to be utilized to prevent cross contamination and prevent infections from spreading. A policy titled Enhanced Barrier Precautions dated 4/1/24, directed staff to use EBP in situations in which exposure to blood and body fluids is anticipated and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands and clothing. EBP were also used for residents with indwelling medical devices, central lines, hemodialysis catheters, feeding tubes and indwelling urinary catheters. High-contact resident care activities included transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, changing linens, indwelling urinary catheter, and wound care. EBP were intended to be used for the duration of a resident's stay.