STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Care Center White Bear Lake	1900 Webber Street White Bear Lake, MN 55110

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately initiate cardiopulmonary resuscitation (CPR) and activate the emergency response system (EMS) when 1 of 1 residents, with a full code status (when a resident's heart stops being (SP) the medical team uses all available lifesaving measures) was found unresponsive. This resulted in an Immediate Jeopardy (IJ) citation when licensed practical nurse, (LPN)-A, was notified by nursing assistant (NA)-A that R1 was unresponsive. LPN-A immediately checked on R1 finding R1 cool to the touch, without pulse and was not breathing. LPN-A failed to assess R1 for irreversible signs of death to determine and if necessary, perform CPR.The immediate jeopardy began on [DATE] when LPN-A failed to assess R1 for irreversible signs of death and did not initiate CPR immediately. The director of nursing (DON) and the Administrator were notified of the immediate jeopardy at 4:35 p.m. on [DATE]. The immediate jeopardy was removed and the deficient practice corrected on [DATE], prior to the start of the survey and was therefore issued at past noncompliance.Findings include: R1's physician order dated [DATE] at 12:23 p.m., indicated R1 was a full code. R1's quarterly Minimal Data Set (MDS) dated [DATE] identified a Brief Inventory Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1's pertinent diagnoses were enterocolitis due to Clostridium Difficile (bacteria of the gut), non-pressure ulcer of the left foot and peripheral vascular disease (progressive circulation disorder). R1 required partial to moderate assistance from staff with all grooming and transfer assistance. R1's progress note dated [DATE] at 2:49 a.m. indicated R1 was found unresponsive at 12:05 a.m., writer called another staff nurse for help. At 12:07 a.m., CPR started, and code blue was announced. At 12:20 a.m. 911 was called, emergency services arrived and took over. At 12:49 a.m. emergency services announced R1 had passed away. R1's family was called to inform them. At 2:35 a.m. the family arrived with the priest to view, and the funeral home was called. Upon interview on [DATE] at 10:59 a.m., licensed practical nurse (LPN)-A stated she last saw R1 alive during evening medication pass around 7:00 p.m. At approximately 12:05 a.m. nursing assistant (NA)-A came to LPN-A and stated R1 had passed away. LPN-A went to check on R1 and noticed R1 looked asleep in her bed with the head of her bed raised with her head tilted to the right. LPN-A stated she was unable to locate a radial pulse, and R1's chest was not rising to indicate she was breathing. She touched R1's forehead and R1 felt cool. LPN-A denied pulling the covers back to assess more of R1's body. LPN-A called the charge nurse, LPN-B, to come and assist her stating before we can do anything we need a second nurse. She denied announcing a code blue, checking for R1's code status or giving instructions to NA-A. LPN-A waited for LPN-B to arrive. Approximately five minutes passed until LPN-B arrived at 12:09 a.m. LPN-B noted R1 was not breathing and looked pale. LPN-B found R1's code status, got the crash cart and initiated CPR. LPN-A stated she would have initiated CPR immediately, however she was a new employee and thought NA-A was agency staff and would not know how to call a code blue, so she wanted assistance (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	from another nurse. She stated if she were aware that NA-A was facility staff she would have had her call the code and assist with CPR. Upon interview on [DATE] at 11:19 a.m. nursing assistant (NA)-A stated she was completing her rounds at approximately midnight and noticed R1's chest was not rising up and down when she entered the room. She turned on the light to try to arouse R1 and R1 did not open her eyes and then she noticed R1 was not breathing. She immediately notified LPN-A. LPN-A called downstairs to get LPN-B to assist her. LPN-B came to the second floor as NA-A and LPN-A were in the hallway outside of R1's room. LPN-B entered the room and immediately yelled out to NA-A to call a code blue and grab the Automated External Defibrillator (AED) machine. Upon interview on [DATE] at 2:05 p.m. the DON stated in the morning of [DATE] LPN-B reached out to her stating she was uncomfortable with how the code status went with R1. LPN-B told the DON that she was called by LPN-A with no urgency as a resident was found unresponsive. LPN-A did not complete a thorough assessment on her own and wanted LPN-B's assistance. LPN-B received a call on the house phone from LPN-A who asked to please come to the second-floor unit to look at something. When LPN-B got to the second floor, she assessed R1 was not breathing, however noted her skin was warm, and no rigor mortis had set in, so she initiated CPR and delegated duties to the staff. The DON was not certain exactly what LPN-A had assessed as during her investigative interview with LPN-A, LPN-A only stated she checked a radial pulse and watched for breaths. The DON had to pull information out of LPN-A asking specific questions if she used a stethoscope to auscultate the breath sounds? Did she pull back the covers to assess R1? Did she note her skin temperature and where? LPN-A had difficulty answering her questions as to what assessment she completed and did not have any nursing notes to verify her assessment by. The DON believed LPN-A reached out to LPN-B to verify R1's death not to assist with CPR. LPN-A also stated that she thought NA-A was an agency staff and therefore was not trained on the facilities emergency protocol. The DON verified with LPN-A that NA-A was a facility staff member who had been trained fully by the facility. Upon interview on [DATE] at 3:02 p.m. LPN-B stated around midnight on [DATE] LPN-A called LPN-B and asked her if she could come to the second floor and look at something quickly. LPN-B stated she did not rush as it was not communicated with her that there was an emergency. When LPN-B arrived on the second floor she noticed LPN-A and NA-A were standing outside of R1's room. LPN-B entered R1's room and noticed R1 was not breathing. She asked LPN-A what R1's code status was, and LPN-A was unable to answer. LPN-B quickly checked her code status and assessed R1 to be without breath, no pulse, the body was warm, and no rigor mortis had set in. LPN-B immediately delegated NA-A and LPN-A to call 911, call a code blue, and one of them assisted in getting R1 on the floor to start CPR. LPN-A called the code over the intercom system saying code blue only once without a room number. LPN-B delegated her to go back and to say code blue three times and give the room number. LPN-B and NA-A positioned R1 on the floor and started chest compressions until another nurse arrived and they started the AMBU bag (a handheld, portable, and self-inflating device used to provide positive pressure ventilation when a person is not breathing), in a few minutes EMS arrived and took over until R1 was pronounced dead. Upon interview on [DATE] at 4:14 p.m. the Administrator stated her expectation was that all staff follow the facilities policies and protocols. A facility policy titled Initiation of CPR/AED and BLS Associate Training Expectations dated 2018 indicated: When it is identified that a resident has signs/symptoms requiring CPR/AED (i.e., unresponsive) and meets criteria, EMS will be activated immediately as follows:911 is called.Door access to EMS is ensured.Resuscitation status is verified.If Provider medical order states a Full Code status, then CPR will be initiated.If Provider medical order states DNR Code status, then CPR will not be initiated.If resident Declination of CPR Form is present, then CPR will not be initiated.If the code status is unable to be confirmed (continued on next page)

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