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	12/11/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a resident's dignity was maintained by not providing a catheter bag cover for 1 of 1 resident (R146) reviewed for catheters. Findings include:R146's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, required partial/moderate assistance with mobility and toileting, and had an indwelling catheter. R146's diagnoses included acute kidney failure, unspecified open wound to right hip and abdominal wall, cellulitis. R146's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 12/2/25, indicated R146 required foley catheter care and was at risk for complications and urinary tract infection (UTI). R146's care plan dated 12/10/25, indicated R146 had an activities of daily living (ADL) self-care deficit and required assistance with ambulation, transferring, mobility, and toileting. R146's provider order dated 12/1/25, indicated, Ensure catheter cover or pant leg is in place to cover urine bag, urinary collection bag should not be visible. During observation on 12/8/25, at 2:43 p.m., R146 was in bed sleeping with urine catheter bag half full containing amber colored urine was hanging on the same side of the bed as the door, exposed for anyone who entered to see. During interview on 12/8/25 at 4:58 p.m., R146 stated did not want everyone seeing her urine. R146 further stated the staff that bring my meals in, therapy and others come in here and it is exposed. R146 stated they did not even cover the bag when she left the room with therapy and just hung it on her walker. During observation on 12/9/25 at 11:42 a.m., R146 was sitting up in the wheelchair with catheter bag exposed. During observation on 12/10/25 at 11:59 a.m., R146 was in bed sleeping with catheter bag exposed hanging on same side of bed as the door. During observation on 12/10/25 at 12:42 p.m., catheter bag still exposed, unidentified therapist into R146's room. During interview on 12/10/25 at 12:45 p.m. nursing assistant (NA)-A stated when residents were up during the day they often had a leg bag placed which would be covered by their pants, otherwise they provide little bags to place the catheter bag in so it would not be exposed and protect the resident's dignity. During interview and observation on 12/10/25 at 12:49 p.m. licensed practical nurse (LPN)-A stated all catheters should be covered, even when the resident was in their room since therapy, social services, activities, visitors and other staff would visit and could see the exposed urine bag. LPN-A stated the urine bags should be covered to maintain a resident's dignity. LPN-A confirmed R146's catheter was hanging on the side of the bed, exposed for anyone to see who entered her room. During interview on 12/10/25 at 2:00 p.m., registered nurse (RN)-A stated the facility did have covers for the catheter bags and should be provided to all residents. RN-A stated the urine bag should be covered for dignity. RN-A further stated the urine bag should be covered even if the resident remains in the room since they could have various visitors who enter the room. During interview on 12/11/25 at 9:32 a.m., director of nursing (DON) would expect urine bags to be covered for dignity. Facility policy Resident Rights and Notification of Resident Rights dated 8/28/25, indicated, The facility acts to protect and ensure the rights of residents.

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a care conference was provided for 1 of 1 resident (R130) reviewed for care conferences.Findings include:R130's quarterly Minimum Data Set (MDS) dated [DATE], indicated R130 admitted into the facility on 7/30/25, and did not hallucinate or have delusions.R130's social service progress note dated 8/1/25 at 1:32 p.m., indicated R130 was cognitively intact. R130's social service progress note dated 8/6/25 at 2:23 p.m., indicated R130 would like assisted living placement but was still MA pending. A care conference was scheduled for August 8th, to discuss discharge planning and recommendations. R130's social service progress note dated 8/8/25 at 3:30 p.m. and recorded as a late entry on 8/11/25 at 9:42 a.m., indicated R130 had a care conference 8/8/25. R130's nursing progress note dated 8/18/25 at 11:02 a.m., indicated R130 was alert and oriented and had new orders to discharge to long-term care. R130's social service progress note dated 8/18/25 at 1:54 p.m., indicated social services spoke with R130 regarding a discharge plan and R130 planned to discharge to the facilities long-term care until her medical assistance was approved and then would like to transfer to an assisted living facility. R130's social service progress note dated 8/18/25 at 3:30 p.m., indicated a care conference would be held at 1:30 p.m., however a date was not specified.R130's Care Conference form saved on 12/11/25, indicated R130's last care conference was dated 8/8/25, and R130's next care conference date would be 11/9/25. The form lacked information R130 had a care conference after 8/8/25.R130's medical record lacked information R130 had a care conference after 8/8/25. During interview on 12/9/25 at 8:08 a.m., R130 stated she hasn't had a care conference and moved over to the long-term care unit in August. During interview on 12/11/25 at 11:54 a.m., social worker (SW)-A stated she sets a care conference schedule for the following week after the MDS is due. SW-A stated care conferences were documented when they are held and viewed R130's medical record and verified there was one care conference documented on 8/8/25, and there was no additional care conferences documented. SW-A viewed R130's MDS and verified R130 had a quarterly MDS dated [DATE], and stated one week after the MDS is completed, a notice was sent for a care conference, however there were no care conferences documented following the MDS dated [DATE]. SW-A further stated R130 was a reliable historian. SW-A stated the purpose of the care conference was to be able to review a resident's status with them and their family and provide opportunities to ask questions. During interview on 12/11/25 at 12:55 p.m., the director of nursing (DON) the care conference was based on the assessment schedule and the SW coordinates a care conference with the resident and family after the MDS is completed. The DON further stated R130 had a quarterly MDS 9/26/25 and should have had a care conference in October. The DON sent an email on 12/11/25 at 1:59 p.m., that indicated they did not have a policy specific to care conference scheduling but follow the RAI (resident assessment instrument) process for timing and coordination. The DON sent an email on 12/12/25 at 3:32 p.m., that indicated they had no additional information and believed the 10/1/25, MDS changes adjusted their dates in their system and caused care conference dates to be adjusted as well.

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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** REVIEWED LNBased on interview and document review the facility failed to ensure an as needed (PRN) antipsychotic medication (medications to treat psychosis related conditions) was prescribed for only 14 days and failed to ensure staff documented use of nonpharmacological interventions used prior to administration of PRN antipsychotic medication 1 of 2 residents (R117) who received PRN antipsychotic medications. Findings include:R117's admission Minimum Data Set (MDS) dated [DATE], indicated R117 had severe cognitive impairment and diagnoses of dementia with severe anxiety. R117 received antipsychotic medications. R117's nursing and provider orders showed the following:-an order dated 11/24/25, indicated R117 required quetiapine (antipsychotic medication) 50 milligrams(mg) every 6 hours as needed for psychosis, dementia with anxiety. This order lacked an end date. -an order dated 10/23/25, indicated R117 required monitoring for target behaviors related to antipsychotic use that included change in sleep pattern, agitation, delusions and hallucinations. The order further directed staff to document behaviors and non-drug interventions provided when behaviors were observed. R117's medication administration record (MAR) dated 11/2025, indicated R117 received PRN quetiapine on 11/25/25 and 11/27/25 for behavior issues.R117's MAR dated 12/2025, indicated R117 received PRN quetiapine on 12/4/25, 12/5/25, and 12/7/25 for behavior issues. R117's care plan dated 10/29/25, indicated R117 used antipsychotic medications for dementia and severe anxiety. Interventions included monitoring of target behaviors as indicated on the electronic MAR and document each shift. R117's medical record lacked indication non-pharmacological interventions were provided before administration of PRN antipsychotic medication.When interviewed on 12/10/25 at 1:13 p.m., registered nurse (RN)-B stated R117 had anxiety and sometimes panic attacks mostly at nighttime. If anxiety was noted, staff tried to calm her or give her a snack, or something to redirect her. When R117 had behaviors, a progress note should be documented to communicate the behavior and what was done. RN-B verified R117 had a PRN antipsychotic medication order with no end date and had received it several times. RN-B stated a progress note should be written when the PRN medication was given to provide more details. When interviewed on 12/10/25 at 1:29 p.m., RN-C stated when administering a PRN antipsychotic medication, the reason it was given, and any nonpharmacological interventions should be documented. RN-C further stated PRN antipsychotic medication orders needed to be limited to 14 days and then re-evaluated by the provider. RN-C verified R117's quetiapine had no end date and there was no documentation of non-pharmacological interventions tried before giving the quetiapine. When interviewed on 12/11/25 at 10:06 a.m., the Director of Nursing (DON) expected orders for as needed antipsychotic medications to be limited to 14 days. DON further expected documentation to the reason why the PRN medication was used and what interventions were tried prior to administration. When interviewed on 12/11/25 at 1:46 p.m., the clinical pharmacist (CP) expected any PRN antipsychotic medication to be limited to 14 days and document the behaviors and other interventions attempted. A facility policy titled Psychotropic Medication Use revised 9/7/23, directed PRN orders for antipsychotic drugs are limited to 14 days. Furthermore, the policy directed documentation to reflect monitoring of target behavior monitoring and nonpharmacological interventions provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R677Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene for nail care was provided for 1 of 1 resident (R6) reviewed for activities of daily living (ADLs) and were dependent on staff for their care. Findings include:R6's quarterly Minimum Data Set (MDS), dated [DATE], identified R6 had diagnosis for Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R6 had moderate cognitive impairment, additionally R6 required partial/moderate assistance with personal hygiene cares.R6's care plan revised dated 10/22/25, identified R6 had and ADL self-care deficit with grooming, required assistance of one by staff.R6's weekly skin checks documentation on 12/8/25 at 2:32 p.m., identified R6 had a shower and nail care was not necessary.During observation and interview on 12/8/25 at 5:42 p.m., R6 stated he asked staff multiple times to cut nails, the staff replied that a nurse or doctor had to cut them. Nails were long and sharp family member (FM)-B had attempted to cut nails, however, fingers on left hand were curled and she was nervous, didn't want to cut the skin.During interview on 12/9/25 at 1:40 p.m., R6 stated nails still had not been cut, they were sharp, long, and did not like it.During observation and interview on 12/10/25 at 9:16 a.m., R6's fingernails on both hands were approximately 1/4 inches long, and jagged with sharp edges. R6's left fingers were curled into palm of hand, extended fingers to observe nails. R6 stated attempted to cut own fingernails, stated asked staff again, they replied a doctor needed to cut fingernails. Fingernail clippers observed on the floor under the television in R6's room.During interview on 12/10/25 at 9:40 a.m., certified nursing assistant (CNA)- B stated finger nails were cut on bath day, sometimes they would be cut on the weekends. There was not a risk to performing cutting R6's fingernails.During interview on 12/10/25 at 11:20 a.m., registered nurse (RN)-C stated with R6 it was not necessary to have a doctor cut nails. Residents should not be clipping own fingernails. She reported she was not aware nail care was not performed, according to the weekly skin assessment documentation, nails were not necessary.During observation on 12/10/25 at 12:06 p.m., RN- C confirmed fingernail clippers were on R6's floor located under television and promptly removed them.During interview on 12/11/25 at 2:40 p.m., Director of Nursing (DON) nails to be checked and completed if needed weekly on bath/shower day. The documentation was under Weekly Skin Check. Nail care was important to reduce injury, for dignity and infection control.A policy titled, Activities of Daily Living (ADL) dated 6/2021, stated residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident attended a scheduled urology appointment for 1 of 1 residents (R146) reviewed for appointments.Findings include:R146's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, required partial/moderate assistance with mobility and toileting, and had an indwelling catheter. R146's diagnoses included acute kidney failure, unspecified open wound to right hip and abdominal wall, cellulitis. R146's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 12/2/25, indicated R146 required foley catheter care and was at risk for complications and urinary tract infection (UTI). R146's care plan dated 12/10/25, indicated R146 had an activities of daily living (ADL) self-care deficit and required assistance with ambulation, transferring, mobility, and toileting. R146's hospital discharge orders dated 11/26/25, indicated, You have an appointment at MN Urology for your follow up on December 2nd at 10:40 am.Your foley catheter should remain in place until you are seen at this appointment. R146's provider order dated 12/4/25, indicated, Patient to reach out [sic] urologist to see if the Foley [catheter] can be removed [Can be removed from Wound Perspective]. During interview on 12/8/25 at 4:58 p.m., R146 stated was not sure how long she was going to need the catheter and that it had been in for over a month. R146 was concerned that she was at risk for another UTI since it had been in for so long and did not want to have to go home with it. During interview on 12/10/25 at 9:04 a.m., R146 stated did not remember seeing a urologist since admission to facility and was not aware of any upcoming appointments to see a urologist. During interview on 12/10/25 at 1:06 p.m., nurse practitioner (NP)-A stated not sure about any urology appointment and that the facility had a scheduler who took care of those things. NP-A further stated triage was notified over the past weekend of R146 experiencing UTI symptoms and that an order was provided for staff to collect a urine sample for lab. P-A further stated the catheter should have been pulled and replaced at that time as well but could not say for sure if that had happened. NP-A stated R146 had been experiencing a lot of drainage and other complications with her wounds and wound vac and not sure it would be appropriate to remove the urine catheter at this point, but would defer to the specialists. During interview on 12/10/25 at 1:08 p.m., health information tech (HIT)-A stated she reviewed orders upon admission and would discuss any referrals for appointments with residents. HIT-A stated she sometimes she would actually schedule the appointment and sometimes the resident would set it up, if it had not already been scheduled prior to admission. HIT-A further stated she would work with family members to see if they would provide transportation or if the resident needed other arrangements which then she would complete. HIT-A further stated she would put a packet together for the resident to take along to the appointment and would receive the packet back upon their return and would scan all documents into the electronic health record (EHR). HIT-A stated if there was nothing scanned into the EHR about R146's urology appointment, then she did not go to it. HIT-A could not explain why R146 missed the urology appointment and could not remember making any arrangements for it. During interview on 12/10/25 at 1:31 p.m., patient services representative (PSR)-A stated R146 was scheduled for MN Urology appointment on 12/2/25 at 10:45 a.m., but could see from the schedule that R146 was a no show. During interview on 12/10/25 at 1:50 p.m., family member (FM)-A stated not being aware of R146 attending any urology appointment and was not contacted for any transportation arrangements. FM-A further stated no aware of any future scheduled appointments. During interview on 12/10/25 at 2:00 p.m., registered nurse (RN)-A stated HIT-A was responsible for managing resident appointments and arranging for transportation to those appointments. RN-A stated could not explain why R146's appointment was missed and there should have been some follow up. During interview on 12/11/25 at 9:32 a.m., director of nursing (DON) stated expectation for residents to attend scheduled appointments with assistance from staff on (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transportation arrangements. DON stated if a resident chose to cancel an appointment, there should be something documented in the EHR regarding that decision. A facility policy on appointment management was requested but not provided.

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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 ensure a mechanical lift was sanitized between use and furthermore, the facility failed to ensure personal protective equipment (PPE) was donned prior to a transfer for 1 of 1 resident (R5) reviewed for enhanced barrier precautions (EBP).Findings include:R41:R41's admission Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment, had a wheelchair, and was dependent on staff for transferring from R41's chair to the bed and the bed to the chair.R41's care plan dated 11/24/25, indicated R41 had a self-care deficit due to progressive weakness and declining condition and required two staff assistance with a Hoyer lift (a full body mechanical lift) for transfers. R5:R5's quarterly MDS dated [DATE], indicated R5 refused a chair to bed and bed to chair transfer, required substantial assistance with rolling in bed, was at risk of developing pressure ulcers and had two unstageable pressure injuries.R5's Active Orders form undated and saved on 12/10/25 at 10:19 a.m., indicated the following orders:12/8/25, enhanced barrier precautions due to wounds to leg and spine. R5's care plan dated 12/8/25, indicated R5 required enhanced barrier precautions due to active wounds and R5's goal was not to develop signs or symptoms of an acute infection. Interventions indicated to assess resident for EBP need and implement precautions according to facility protocol, post clear signage on the door or wall outside the resident room indicating the type of precautions and required PPE, staff to apply gloves and gowns prior to high-contact care activities, discard PPE in designated location following activities, and sanitize hands after PPE removal. R5's care plan dated 10/29/25, indicated R5 had a self-care deficit and required two assist of staff with a Hoyer lift for transfers. During observation on 12/8/25 at 1:00 p.m., R41 and R5's room had signage on the door that indicated EBP was required.During observation on 12/10/2025 between 9:38 a.m., and 9:57 a.m., nursing assistant (NA)-C entered R41 and R5's room and at 9:43 a.m., NA-D went into the room and left the room at 9:47 and grabbed the mechanical lift that was in the hall. NA-C and NA-D had the lift sling under R41and transferred R41 from her bed into her chair. At 9:51 a.m., NA-C moved the mechanical lift to R5's side of the room. The lift contained a pocket for Super Sani-Cloths (a germicidal disposable wipe used for cleaning and disinfecting surfaces), however neither NA-C nor NA-D wiped down the mechanical lift after use with R41. NA-C and NA-D did not don a gown or gloves. At 9:54 a.m., NA-C and NA-D lifted R5 from her bed with the same mechanical lift to her chair. R5 had a dressing to the right lateral side of her leg. NA-C and NA-D assisted in transferring R5 into her chair. The lift had not been wiped down between R41 and R5's transfer. NA-C verified R5 had two dressings to R5's right leg. At 9:57 a.m., NA-C brought the mechanical lift out of R41 and R5's room and into the hall and re-entered the room without wiping down the mechanical lift. During interview on 12/10/25 at 9:59 a.m., NA-C stated R5 had sores on her legs and thought staff donned a gown when changing R5's dressing. NA-C further stated EBP included residents with wounds and staff had to don gowns and gloves and verified NA-C and NA-D did not wear a gown or gloves when assisting R5 with a transfer and did not clean the mechanical lift between use. NA-C stated they had been instructed to clean the lift after every resident use. During interview and observation on 12/10/25 at 10:03 a.m., NA-D stated R5 was on EBP when staff tend to her wounds. NA-D further stated nurses had to wear gowns, but the NA's did not do anything with the wounds and therefore did not have to adhere to EBP. NA-D verified mechanical lifts should be wiped down between resident use and did not wipe the mechanical lift down. Signage on R41 and R5's door indicated everyone must clean hands before entering and leaving the room and providers must wear gloves and gown in the following high contact resident activities, dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting and device care and wound care. During interview on 12/10/25 at 10:28 a.m., registered nurse (RN)-B stated staff should don gloves and gowns during transfers if a resident had a wound. Further, RN-B verified the mechanical lift contained Super Sani-Cloths and expected staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wipe down the mechanical lift between use and stated R5 required EBP because she had wounds and further stated it was important to wipe the lift and follow EBP because they didn't want to spread bacteria to someone. During interview on 12/10/25 at 10:33 a.m., registered nurse (RN)-C stated she planned to ask the director of nursing (DON) about EBP and thought staff should don PPE with transfers but was not sure and expected staff use the Super Sani-Cloths between resident use. During interview on 12/11/25 at 11:16 a.m., the infection preventionist (IP) stated she expected staff don a gown and gloves whenever they are providing cares that are included on the door and expected staff clean lifts between residents and further stated this was stressed during new orientation of staff in order to prevent the spread of infections. During interview on 12/11/25 at 12:55 p.m., the director of nursing (DON) stated she expected staff follow precautions per the EBP signage on the door and further stated she expected mechanical lifts be sanitized between residents. A policy, Standard Precautions for Infection Control, dated 2014 and 2015, indicated staff would use care in handling client care equipment in order to prevent skin and mucus membrane exposure, contamination of clothing, and transfer of microorganisms to other patients or environments. Ensure that reusable equipment and environmental surfaces are appropriately cleaned and reprocessed prior to use on another client. A policy, Enhanced Barrier Precautions, dated 2019, indicated EBP was a strategy in nursing homes to decrease the transmission of CDC targeted and other epidemiologically important multidrug-resistant organisms (MDROs). Residents at risk for MDROs, specifically those with an indwelling medical device and or chronic wounds requiring a dressing will be required to use EBP. EBP refers to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Furthermore, the policy outlined high-contact resident care activities to include dressing, bathing, transferring, hygiene, changing briefs, chronic wound care and with indwelling medical device care or use.