STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Marian of St Paul LLC	200 Earl Street Saint Paul, MN 55106

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48037 Based on interview and document review the facility failed to report an incident involving a fall was immediately reported to the supervisor according to the facility abuse policy for 1 of 4 residents (R1) who suffered a fracture during an unsafe transfer that caused a delay in care and treatment for over 12 hours. Finding include: During interview on 8/14/24 at 1:29 p.m., R1 reported being transferred incorrectly on 7/29/24 in the shower causing her to fall; she landed on her butt with her right leg and ankle underneath herself. R1 screamed in pain and told staff she was hurt. R1 was unable to identify staff as she reported being legally blind and was not provided her hearing aids prior to the transfer. R1 reported it took a whole other day to get anyone to look at it. R1's quarterly MDS (minimum data set) dated 6/20/24, identified R1 as cognitively intact, moderate difficulty with hearing and requires the use of a hearing aids. R1 had highly impaired vision. Tub/shower transfer was not assessed (N/A). R1 required substantial/maximal assistants taking off and putting on footwear. R1's progress note dated 7/30/24 at 10:07 a.m., included nursing assistant (NA) reported resident had a bruise on right ankle. It measured 8.50 centimeters (cm) by 4.40 cm R1 stated she cannot bear weight on right ankle. Painful to touch. Also has bruising on anterior side of right foot. R1's x-ray report titled final report dated 7/30/24 at 5:18 p.m., identified R1 sustained a displaced oblique fracture of the distal fibula (ankle fracture) at the level or the ankle joint and probably a minimally displaced avulsion of the posterior malleolus as well. Facility reported incident (FRI) submitted to the State Agency (SA) on 7/30/24, indicated on 7/29/24, at 7:00 p.m. R1 reported to nursing home staff she was pivot transferred with assist of one staff person (instead of the standing mechanical lift). R1 could not remember details, but remembered having a hard time reaching the grab bar, she stood up to hold onto the back of the chair and landed on her ankle wrong. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/14/24 at 12:39 p.m. NA-A stated she had worked the evening of 7/29/24 when R1 was assisted to the floor in the shower room. NA-A stated R1 was supposed to use the EZ-stand but transferred R1 by a standing pivot. R1 became weak during the transfer and so NA-A assisted R1 to the floor. When R1 got to the floor she reported pain in her leg. NA-B called for help over the walkie talkie. NA-B and NA-C helped get R1 off the floor and back in her wheelchair using a full body mechanical lift. The reason NA-A did not report R1's fall and new onset of pain was due to registered nurse (RN)-A being busy and having a bad attitude. NA-A did not report to oncoming RN or nursing assistants due to not thinking of it. During interview on 8/15/24 at 10:15 a.m., NA-B stated she worked on 7/29/24, the evening R1 fell . NA-B was called on the walkie talkie by NA-A around 7:30 p.m. or 8:00 p.m. When NA-B entered the shower room, R1 was partially sitting and laying on her side, one of R1's legs was backwards and one was forward, and she was barefoot. NA-B stated, NA-A had told her she had guided R1 to the ground. NA-C arrived to the shower room shortly after NA-B and they transferred R1 to her wheelchair. NA-A explained a nurse was not present during the transfers and had assumed NA-A had notified the nurse of the fall. During return call on 8/16/24 at 3:34 p.m., NA-C reported hearing someone needed help in the shower room on 7/29/24. Upon entering the shower room R1 was clothed, barefoot, and was laying on the ground without a gait belt on. NA-C was unaware why R1 was on the floor. NA-C indicated a nurse was not present and she had not notified a nurse of the incident. During interview on 8/15/24 at 11:40 a.m., registered nurse (RN)-A reported to be R1's nurse the night of 7/29/24 and was unaware R1 had a fell . RN-A reported NA-A never provided report that night and left her shift without notifying anyone. Additionally, there was no communication of a floor transfer by NA-B or NA-C with knowledge who had knowledge R1 had been on the floor. RN-A did give the oncoming shift report, but due to not knowing reported R1 was fine. During interview on 8/16/24 at 9:56 a.m., clinical manager (CM)-A reported employees are to follow care plans and care guides and transfer as directed. Nursing assistants are expected to notify a nurse immediately if there was a fall and/or increases in pain so the nurse could fully assess. A delay of care could happen and cause further concerns if not reported. Nurses are the only ones to be able to assess following a fall. All staff are to follow policy and procedures related to this. During interview on 8/16/24 at 10:14 a.m., Administrator and director of nursing (DON) reported R1's fall as preventable and a delay in response to R1's pain due to a lack of reporting. Administrator and DON reported R1 was at risk due to the lack of reporting as R1 could have been further injured if oncoming staff attempted to transfer R1 or had R1 stand. All staff are expected to follow the policy and procedure related to reporting. Policy titled Abuse Prevention Plan with last review date of 7/21/22, identified : Willful: the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 1.Prevention of Abuse, Neglect, Misappropriation of Resident Property, and Financial Exploitation In order to prevent abuse, neglect, misappropriation of resident property, and financial exploitation, the facility shall do the following: a. Require staff to report concerns, incidents, and grievances immediately to their supervisor. Ensure concerns, incidents, and grievances are promptly investigated and appropriate steps are taken to minimize the likelihood of re-occurrence. b. Supervisors or managers shall provide daily supervision of direct care staff to identify inappropriate behaviors, communication quality, physical contact, and/or burn out. b. Report within the timelines of the guidance: cStaff will notify the facility Charge of Building immediately of any reports of possible abuse, neglect, misappropriation of resident property, and/or financial exploitation. The Charge of Building will immediately notify the Administrator, Director of Nursing, and Director of Social Services. cIf the event that caused the suspicion involves abuse or results in serious bodily injury, the individual is required to report the suspicion to the state immediately, but not later than 2 hours after forming the suspicion. If the event does not involve abuse and does not result in bodily injury, the individual is required to report to the state no later than 24 hours after forming the suspicion.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 48037 Based on observation, interview, and document review the facility failed to provide safe transfers according to the care plan, to prevent or mitigate risk of falls and/or falls with major injury, for 4 of 4 residents (R1, R2, R3, R4) who required staff assistance to transfer. This resulted in an immediate jeopardy (IJ) for R1 when she suffered an ankle fracture during a transfer. The IJ began on 7/29/24 when NA-A did not follow R1's care plan to use a standing lift (EZ-Stand) for transfers, R1 became weak and was assisted to the floor resulting in R1's ankle fracture and probable posterior malleolar fracture. The Administrator and director of nursing (DON) were notified of the immediate jeopardy on 8/15/24 at 3:19 p.m. The immediate jeopardy was removed on 8/15/24 but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1's Face Sheet dated 8/24/22, identified R1 had diagnoses that included unspecified polyneuropathy, repeated falls, weakness, other specified disorders of bone density and structure with multiple sites of osteopenia. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 did not have cognitive impairment. R1 had moderate difficulty with hearing in which she required the use of a hearing aids. R1 also had highly impaired vision. R1 required substantial/maximal assist to don/doff foot wear. Tub/shower transfer was not assessed (N/A) but the quarterly MDS dated [DATE], identified R1 was totally dependent on staff for tub/shower transfer. R1's care plan dated 8/25/22, identified R1 had self-deficits with activities of daily living (ADL) with bathing, grooming, oral cares, ambulation, transferring, mobility, vision, and bowel/bladder. R1 required assist of one staff to assist with bathing and required assist of one with a mechanical standing lift (EZ-Stand) for transfers. R1's care plan dated 8/25/22, indicated R1 was at risk for falls related to history of falls, weakness, R1 did not wait/remember to ask for assistance, polyneuropathy, anxiety, and had visual impairment. Interventions included staff were to provide proper, well-maintained footwear. Facility reported incident (FRI) submitted to the State Agency (SA) on 7/30/24, indicated on 7/29/24, at 7:00 p.m. R1 reported to nursing home staff she was pivot transferred with assist of one staff person (instead of the standing mechanical lift). R1 could not remember details, but remembered having a hard time reaching the grab bar, she stood up to hold onto the back of the chair and landed on her ankle wrong. R1's progress note dated 7/29/24 at 1:18 a.m., identified R1 had a shower during the shift. R1's record did not include any documentation of the incident that was reported to the SA and did not identify any nursing care or treatment was provided to R1 following the fall until 7/30/24. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's progress note dated 7/30/24 at 10:07 a.m., included nursing assistant reported resident had a bruise on right ankle. It measured 8.5 centimeters (cm) by 4.4 cm. R1 stated she could not bear weight on her right ankle. Painful to touch. Also has bruising on anterior side of right foot. R1's x-ray report titled final report dated 7/30/24 at 5:18 p.m., identified R1 sustained a displaced oblique fracture of the distal fibula (ankle fracture) at the level or the ankle joint and probably a minimally displaced avulsion of the posterior malleolus as well. R1's fall report indicated on 7/29/24. R1 had a fall in the shower room (time of fall was not identified) Interdisciplinary team (IDT) met to review R1's fall in which she was transferred inappropriately. R2 sustained a fracture to her right ankle. Pain is being managed with Tramadol, Tylenol, and elevation. Intervention: staff education. Resident is non-weight bearing to the right leg. She is now a Hoyer lift (full body mechanical lift). The facility's investigative file included R1's nursing assistant (NA) care sheet (abbreviated care plan used by NA's) used on the date of the fall indicated: R1 required assist of one staff with EZ-Stand with transfers. Vision impaired. Blind in Right, blustery in left. Hearing: hearing aids prefers to wear left hearing aid. R1 was a fall risk and staff were to encourage to wear nonslip socks at all times. During interview on 8/14/24 at 1:29 p.m., R1 stated staff were supposed to use the EZ-stand every time they transferred her, but that did not happen all the time. They [staff] think they can transfer me by myself [without the lift], I am just too heavy. R1 remembered the night she fell in the shower room very well. R1 recalled sitting on the shower chair, NA-A did not provide her with her hearing aids so she could hear and did not put anything on her feet. NA-A did not even put a gait belt on prior to telling her to stand up and hold onto the wheelchair that was not stable. R1 stated at the time, she was very worried and scared she was going to fall. R1 was standing up when she fell on to her leg which slid underneath her bottom so that she was partially lying and sitting on the floor. R1 screamed out in pain and knew something was wrong right away. She then was transferred by multiple staff with the Hoyer lift to her wheelchair that was in the shower room. R1 was pushed to her room, then transferred to the bed with the standing lift by one staff member but she was not sure which one. R1 stated she was not sure if a nurse was in the shower room or her room after the fall because she was blind and could not see the staff's faces or name tags. R1 explained it took a whole day for someone to look at her ankle even though she was reporting pain to nursing staff. R1 expressed safety concerns with staff not knowing what's going on or what I need. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 8/14/24 at 12:39 p.m. NA-A stated she had worked the evening of 7/29/24 when R1 fell . NA-A stated R1 was supposed to use the EZ-Stand but transferred R1 by a standing pivot during her shifts for the last 11 months because that's the way I did it. NA-A indicated R1 was in the shower room sitting on the shower chair with her pants down around her upper legs. Once NA-A helped R1 to stand, R1 did not use the grab bar because NA-A told R1 to hold onto her wheelchair that was facing her. While R1 was arched over her chair, NA-A started pulling up R1's pants but R1 could not stand anymore because she became weak and started sliding down so NA-A assisted her to the floor. NA-A asked R1 if she was in pain and R1 said her leg was hurting. R1 had not reported pain in her leg before, during or after her shower until after she went down to the floor. NA-A indicated she called for help in the shower room. NA-B and NA-C responded they used a Hoyer to get R1 back to the wheelchair. Then pushed R1 to her room where NA-A used the EZ-stand to get R1 back into bed because her leg was hurting. NA-A explained she used the EZ-Stand instead of the Hoyer so R1 would not have to put so much weight on her leg. NA-A was not aware easing someone down to the floor was considered a fall. The reason NA-A did not report R1's fall and new onset of pain was because registered nurse (RN)-A was busy and had a bad attitude. NA-A did not report to oncoming RN or nursing assistants because she was not thinking of it. During interview on 8/15/24 at 10:15 a.m., NA-B stated she worked on 7/29/24, the evening R1 fell . NA-B was called on the walkie talkie by NA-A around 7:30 p.m. or 8:00 p.m. When NA-B entered the shower room, R1 was partially sitting and laying on her side, one of R1's legs was backwards and one was forward, and she was barefoot. NA-B reported R1 was not wearing a gait belt and there was no gait belt in the shower room. NA-B stated, NA-A had told her she had guided R1 to the ground. NA-C arrived to the shower room shortly after NA-B, at which point NA-A directed NA-C to go get the Hoyer (brand name of full body mechanical lift). After the three of them transferred R1 to her wheelchair NA-B and NA-C left the shower room. NA-B reported R1 stated she was fine and did not display or report pain. NA-A explained a nurse was not present during the transfers and had assumed NA-A had notified the nurse of the fall. NA-B was unaware if lowering a resident to the floor was considered a fall. During return call on 8/16/24 at 3:34 p.m., NA-C reported hearing someone needed help in the shower room on 7/29/24. Upon entering the shower room R1 was clothed, barefoot, and was laying on the ground without a gait belt on. NA-C was directed by NA-A to go get a Hoyer. NA-C stated R1 was then transferred off the floor to wheelchair. NA-C was unaware why R1 was on the floor and left the room after R1 was transferred to the chair. NA-C did not have any other contact with R1 that evening. NA-C stated R1 did not report pain or notice non-verbal signs of pain. NA-C indicated a nurse was not present and she had not notified a nurse of the incident. NA-C was unaware if lowering a resident to the floor was considered a fall. During an interview on 8/14/24 at 2:22 p.m., trained medication aid (TMA)-A stated she worked the evening of 7/29/24. NA-A did not report anything to her about a fall. NA-A mentioned a rough transfer and no further information. TMA-A reported witnessing NA-A transfer R1 with the EZ-Stand from wheelchair to bed on 7/29/24 following the shower and R1 did not appear to be in discomfort at that time. About half hour after R1 was in bed she complained of pain in her foot and leg so she applied the muscle rub that she could have when she needed it. TMA-A applied the muscle rub again that evening but could not recall the time. TMA-A did not see any swelling or bruising and R1 had not reported she was having excessive pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 8/15/24 at 11:40 p.m., registered nurse (RN)-A reported to be the nurse for R1 on the nightshift of 7/29/24. RN-A was not notified of any falls for R1. RN-A stated NA-A never gave report before leaving for break or the end of her shift. RN-A stated she had completed a skin check on R1's body after the shower while R1 was in bed but did not find any concerns and R1 did not mention any pain. RN-A was notified by the director of nursing (DON) of R1's fall the next day when facility staff went to get R1 up and R1 reported pain. During interview on 8/16/24 at 9:56 a.m., clinical manager (CM)-A reported through her investigation R1 was not wearing a gait belt at the time of the fall. R1's fracture was identified on the morning of 7/30/24, after R1 reported pain to a NA who then reported to a licensed practical nurse (LPN). CM-A explained staff were not to stand R1 up without the use of an EZ-Stand. R1 should have been assessed by a nurse prior to getting her up from the floor. NAs were not trained to complete assessments to determine if there were injuries that were not obvious. CM-A indicated since the fall was not reported to a nurse timely it did cause a delay in necessary care and treatment of R1's fracture. CM-A indicated all falls should be reported immediately so a delay in services could be avoided. CM-A reported all three nursing assistants NA-A, NA-B and NA-C should have reported the fall after it happened. R1's fall was preventable if the care plan was followed. During interview on 8/15/24 at 11:14 a.m., physical therapist (PT)-A recalled being notified R1 had fallen during a transfer with a nursing assistant who did not use an assistive device or gait belt. R1 did not have adequate standing tolerance and would not be able to stand long enough to pull up her pants and transfer simultaneously. PT-A expected R1's legs would give out and should not have transferred without the use of an EZ-Stand due to risk of falling. Since the fall, R1 was now no weightbearing on the right leg and was in an immobilizer. During interview on 8/16/24 at 10:14 a.m., Administrator and director of nursing (DON) reported the causal factor for why R1 fell was due to an improper transfer due to staff not following the care plan and R1's fall was preventable. When staff do not follow the care plans there is a risk of causing harm to the residents. All staff should be aware of need to report a fall immediately; unintentionally coming to the ground was considered a fall. There was a delay in response to R1's pain because of the late reporting which could have caused increased pain. Additionally, oncoming staff members could have caused more damage when attempting to transfer without awareness of a previous fall. R4's Face Sheet dated 7/9/24, identified diagnoses which included other abnormalities of gait and mobility, lack of coordination, repeated falls, cognitive communication deficit, weakness, syncope and collapse and bilateral sensorineural hearing loss. R4's quarterly MDS dated [DATE], identified R4 had severe cognitive impairment. R4 required assist substantial/maximal assist to go from lying to sitting at the edge of the bed. R4 required substantial/maximal assist for sitting to standing and partial moderate assist for chair to bed transfer. R4's care plan dated 8/28/23, identified R4 required assist with bed mobility, transfers, ambulation, and locomotion due to rheumatoid arthritis. R4 required stand by assist with gait belt for all transfers. R4's undated care sheet identified R4 required A1 [assist of one] bed and transfers independently W/C [wheelchair]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's undated nurse report sheet identified R4 transferred independently. During observation on 8/15/24 at 9:20 a.m., NA-F was transferring R4 from the edge of the bed to the wheelchair that was directly in front of R4. Although NA-F had a gait belt around R4, NA-F laced her arms under R4's under arms and lifted R4 to standing position. R4's shoulders were above R4's ears during the lifting process. R4 yelled Ouch! Ouch! Ouch! at which point the surveyor directed NA-F to stop the transfer and allow R4 to sit back on the edge of the bed. Second attempt NA-F used R4's transfer belt to lift R4 to a standing position however R4's knees bent and was not standing in a straight up. While R4 was in that position, R4 leaned forward to hold onto the wheelchair in front of her for support. R4 was unable to lift her feet to start the 180-degree pivot after several attempts. Surveyor again directed NA-F to stop the transfer a second time. A second nursing assistant NA-E arrived. NA-E raised the bed and moved R4's wheelchair for a 90-degree pivot transfer. NA-E used physical assistance and a gait belt help R4 to a straight up standing position and completed the 90-degree pivot to R4's wheelchair with no instability noted. During interview on 8/15/24 at 9:42 a.m., nursing assistant (NA)-F indicated the difficult part of R4's transfer was lifting R4 up to stand. NA-F explained knew R4 was having trouble with the transfer because she was breathing heavy, had difficulty standing and moving her feet. NA-F stated the purpose of the gait belt was to prevent the resident from falling and explained she was trained by other staff to not use under the arms or clothing for lifting. NA-F admitted when residents needed assistance with a transfer, NA-F would assist them by holding under their arm pits, have them stand up, and give verbal ques to turn slowly. NA-F reported next time she plans on using the gait belt for lifting. Raising the bed by NA-E really helped. During interview on 8/14/23 at 1:56 a.m., NA-E reported staff should never go against the transfer status in the care plan for residents or go against resident care sheets. Assist of one means one staff to physically assist with the use of a gait belt. If there was weakness or any other concerns with a resident's ability to transfer, then the transfer should be stopped, and the nurse notified. R2's Face Sheet dated 11/30/2023, identified R2 had diagnoses that included Alzheimer's disease, cognitive communication deficit, unspecified dementia, weakness, other abnormalities of gait and mobility, repeated falls, left shoulder- rotator cuff insufficiency, other disorders of bone density and structure and left lower leg-subchondral sclerosis (thickening of bone). R2's annual MDS dated [DATE], identified R2 had severe cognitive impairment. R2 was independent to go from lying to sitting on the side of the bed, supervision or touching assistance for the ability to go from sit to stand and was independent for chair to bed transfer. R2 required partial/moderate assistance for toilet transfers. R2's care plan dated 7/13/23, identified R2 had activity of daily living (ADL) deficits and needs assist with bed mobility, transfers, ambulation, locomotion bathing, AM/HS (morning/night) cares, toileting, and meal set up due to Alzheimer's disease and other comorbidities. R2 required staff assist of 1 contact guard assist (CGA) for all transfers using a gait belt for support. R2's undated care sheet identified R2 required Bed: A1 Transfers: A1 R2 was noted to be a fall risk. R2's nurse report sheet undated, identified R2 transfer: A1 WC; use gait belt while on transfer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation on 8/14/24 at 2:54 p.m., R2 was noted to be laying perpendicular in bed. NA-C grabbed R2's right arm and pulled him forward and then pushed on R2's back so that R2 was sitting upright on the edge of the bed. NA-C placed wheelchair directly in front of R2. NA-C then laced her left arm under R2's under arm and pulled on R2's pants to bring R2 to a standing position without the use of a gait belt or walker. Once in the standing position, R2 was unsteady so he grabbed onto the wheelchair arm rest for support while NA-C held onto R2's pants to complete a 180-degree turn. During interview on 8/14/24 at 3:02 p.m., NA-C reported R2 sometimes needed a transfer belt, but this time he did not; NA-C did not offer a reason as to why R2 did not need a transfer belt. NA-C stated she was able to assist R2 to the chair by using her body to lift and help guide R2 upright into the chair. NA-C would use a transfer belt with R2 if he was fatigued. R2 had a walker that was in the bathroom, but she did not need it because he wasn't walking anywhere, just turning and did not need it. NA-C knew how to transfer R2 by the care sheets which listed R2 needed assist of one staff but did not identify R2 required a gait belt for transfers. NA-C stated if a resident needed a gait belt it would say on the care sheet. During interview on 8/14/24 at 3:12 p.m., registered nurse RN-(C) stated R2 was an assist of one with gait belt. RN-C knew R2 needed the gait belt because it was on the nurse report sheets. RN-C explained nurses and nursing assistants have different care sheets which were worded differently. RN-C was unsure why they were worded differently, and CM-A would make the changes when necessary. RN-C indicated the nurse report sheets and the care sheets should match what was in the care plan. R3's Face Sheet dated 10/20/23, identified R3 had diagnoses that included lack of coordination, unspecified dementia, other abnormalities of gait and mobility, age related osteoporosis without current pathological fracture, other specified disorders of bone density and structure multiple sites- osteopenia, repeated falls, cognitive communication deficit and weakness. R3's quarterly MDS dated [DATE], identified R3 had severe cognitive impairment. R3 required patrial to moderate assistance lying to sitting at the edge of the bed, substantial/maximal assist to complete sit to stand and supervision or touching assist for chair to bed transfer. R3 required supervision or touching assistance for toilet transfers. R3's care plan dated 12/19/23, identified R3 required assist of one to get on and off the toilet. Required assist to toilet upon rising, after meals, HS (night) and as requested. Staff should stay with R3 while seated on the toilet to prevent falls. R3's care plan dated 11/1/23, identified R3 had impaired mobility related to weakness. R3 was to maintain ability to transfer with assist x1, FWW (four wheeled walker) and wheelchair to follow with gait belt. R3's care sheet undated, identified R3 required Bed: Ax1 Transfers Ax1 and was noted to be a fall risk. R3's nurse report sheet undated, identified R3 transferred with A1 WC. During observation on 8/14/24 at 3:27 p.m., R3 was sitting on the toilet and being assisted by NA-C. R3 stood up off the toilet without a gait belt on. NA-C grabbed and pulled on the back of R3's pants while R3 completed the pivot to her wheelchair. Licensed practical nurse (LPN)-A observed this and instructed NA-C to use a gait belt. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Marian of St Paul LLC	200 Earl Street Saint Paul, MN 55106

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 8/14/24 at 3:36 p.m., licensed practical nurse (LPN)-A reported R3 did need a gait belt and a gait belt should be used with all residents. During interview on 8/14/24 at 3:40 p.m., NA-C reported R3 did not need a gait belt because R3 was able to stand independently. During interview on 8/15/24 at 9:29 a.m., nursing assistant (NA)-D stated she knew how to care for residents by looking at the care sheets. During interview on 8/15/24 at 10:13 a.m., occupational therapist (OT)-A reported all staff were to use a gait belt for all transfers except when a resident used an EZ-Stand and Hoyer. Contact guard assist (CGA) required a care givers hand on the resident. Whereas standby assist and/or supervision a hand may or may not be needed. The purpose of the gait belt was to keep the resident stable and stationery. The only time a staff member did not need a transfer belt was if they were fully independent in the room. During interview on 8/16/24 at 9:56 a.m., clinical manager (CM)-A reported facility expectation was for all nursing staff to give a thorough shift report on what needs to be done and inform of any changes. Nursing assistants were supposed to relay any information about changes, pain and any concerns with transfer status. An assessment by a nurse needed to be done for all falls which would include lowering residents to the ground. Staff were expected to always follow and understand the care plan. During interview on 8/16/24 at 10:14 a.m. director of nursing (DON) and administrator reported all staff should be aware when to report, how to follow their care plans, and use gait belts and appropriate devices for lifting and transferring residents. Staff should not be using resident's extremities, body parts or clothing to lift or move people this could result in injury and/or falls. All staff should be aware of the policies and procedures and follow them. During interview on 8/15/24 at 11:49 a.m., Medical director (MD)-A reported when the care plan identifies assist of one, staff should be using a gait belt. The expectation for contact guard is also for staff to hold onto the gait belt. Staff should not be using part of a resident's body or clothing to lift residents. Policy titled integrated fall management undated. Identified definition of a fall: Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g, onto bed, chair or bedside mat.) The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or nursing home. Falls are not a result of an overwhelming external force (e. g., a resident pushes another resident). Fall refers to unintentionally coming to rest on the ground, floor or other lower level, but not as a result of overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for staff interventions, is considered a fall. A fall fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Post fall procedure step (7) identified when a resident falls the licensed nurse is notified. The nurse completes and assessment of the resident's condition including an interview, if possible, completion of vial signs and a body assessment. A fall defined as an unintentional change in position coming to rest on the ground, floor or onto the next lower surface. Policy titled Safe Patient/Resident Handling and Movement policy dated 4/1/05 directed staff, o patient Handling and Movement Requirements: -The manual lifting or moving of residents is a hazardous task and should be avoided whenever possible. If unavoidable, assess them carefully prior to completion. -Use mechanical lifting devices and other approved patient handling aids for high-risk patient handling and movement tasks except when absolutely necessary, such as in a medical emergency. -Use mechanical lifting devices and other approved patient handling aids in accordance with instructions and training Employees shall: Comply with parameters of this policy. -Use proper techniques, mechanical lifting devices, and other approved equipment/aids during performance of high-risk patient handling tasks per facility policy and manufacturer's guidelines. -Notify supervisor of any injury sustained while performing patient handling tasks. -Notify supervisor of need for re-training in use of mechanical lifting devices, other equipment/aids and lifting/moving techniques. -Notify supervisor of mechanical lifting devices in need of repair and remove equipment from use. -Supply feedback to Supervisor on Safe Patient Handling and movement components, including but not limited to; resident refusal or non-compliance to use equipment and change in resident status that would limit success of the patient handling task. The immediate jeopardy that began on 7/29/24, was removed on 8/15/24, when it was verified the facility implemented the following: The facility reviewed and revised the policies and procedures related to safe patient handling, fall management, and reporting falls. The facility educated licensed staff and nursing assistant's on following the care plans and how to safely transfer residents using a gait belt. The facility developed and implemented competency for staff to demonstrate understanding of safe transfer technique and following the care plan. The facility identified residents who were at risk and review and revised care plans and care guides based as applicable. The facility ensured care sheets reflect the care planned directions for transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility ensured staff are able to communicate level of care for transfers/articulated the type of transfer and if gait belt is not expected to be used for some reason.