

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Cerenity Marian of St Paul LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview, observation, and document review, the facility failed to ensure a self administration of medication assessment (SAM) was completed to allow residents to safely administer their own medications for 3 of 3 residents (R70, R11, R52). Findings include: R70's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, required set up or clean up assist for eating, oral hygiene, and required supervision for upper body dressing, partial assist for lower body dressing and supervision for personal hygiene. R70's Face Sheet form dated [DATE], indicated R70 had the following current diagnoses: metabolic encephalopathy, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, cognitive communication deficit. R70's physician orders were reviewed and lacked an order to self administer medications. An order was later added on [DATE], Ok for daily medications to be left with resident to take independently after set up. R70's care plan was reviewed and lacked interventions to self administer medications. R70's nursing progress notes dated [DATE], indicated R70 was admitted to the facility and was alert and oriented times four. R70's care conference note dated [DATE] at 12:39 p.m., indicated occupational therapy (OT) would complete a med box set up for comprehension of the task. R70's social services note dated [DATE], indicated R70 had intact cognition. R70's Occupational Therapy Progress Report form dated [DATE], through [DATE], indicated R70's goal was to safely and efficiently manage medications with supervision or touching assistance in order to facilitate improved ability to care for self. The report indicated the goal was not attempted due to environmental limitations. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R70's Occupational Therapy Treatment Encounter Notes form dated [DATE], indicated CPT (cognitive performance test) was initiated and indicated for Medbox scored ,d+[DATE]. R70's Occupational Therapy Treatment Encounter Notes form dated [DATE], indicated R70's average CPT score was 5.2. R70's Observation Assessment screen reviewed on [DATE] at 9:26 a.m., from [DATE], to [DATE], lacked a SAM assessment. R70's SAM assessment dated [DATE] at 11:25 a.m., indicated a No next to the question, Does the resident want to self administer medications including, but not limited to oral, creams/oointments, eye drops, nebulized meds? A No response indicated no further assessment was needed, therefore, cognitive status, whether R70 was appropriate to self administer medications, whether R70 would become confused due to frequent changes in drug regimen, whether R70 could name the dosage, frequency, and reason for use of each medication, whether R70 could identify the time and state the time each medication was due, whether R70 could read the prescription label and identify each medication, whether R70 could swallow medications without altering the dispensed form, whether R70 had a history of non compliance, was unanswered. Additionally, questions were unanswered under the heading, Interdisciplinary team (IDT) Evaluation which included whether it was appropriate for R70 to self administer medications, what medications R70 could self administer, and whether to enter a nursing order for self administration. Under the heading, Notes indicated, R70 requested to have medications set up by the facility, however wanted daily medications left on the tray with meals to take independently and the provider was contacted for an order. During interview on [DATE] at 2:10 p.m., R70 stated the facility would not leave his medications for him to take, and did not like staff standing over him to take his medications. R70 stated, I'm not 5 years old. R70 further stated, It's demoralizing. R70 stated he will take his medications and has done so every time they are provided. During interview on [DATE] at 8:28 a.m., registered nurse (RN)-C stated she observes residents until they took their medications and when a resident was admitted to the facility, a SAM assessment was completed. RN-C verified R70 did not have a SAM assessment completed and thought if a resident had episodes of confusion a SAM assessment would not be completed. RN-C viewed R70's progress notes from admission and stated R70 was alert and oriented times four and was coherent. RN-C further stated R70 was capable of making his own decisions and should have had a SAM assessment completed. During interview on [DATE] at 8:44 a.m., licensed practical nurse (LPN)-A stated SAM assessments were completed if a resident felt strongly about self administering medications and SAM assessments were also completed upon admission. LPN-A stated R70 was capable of making his own decisions and verified a SAM assessment had not been completed and should have had one completed. LPN-A stated it was important to complete a SAM because it was a resident's right to do as much as they feel they a capable and further stated a diagnosis of encephalopathy would not disclude a resident from having a SAM assessment. LPN-A further stated they complete a SAM assessment and then get the provider involved and the SAM assessment included information on cognition and once the assessment was completed they had a discussion. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 12:40 p.m., occupational therapist (OT)-B stated R70 was going to stay long term and since nursing took care of R70's medications, R70's goal to safely and efficiently manage his medications was no longer appropriate. OT-B clarified a score of 5.2 on a cognitive performance test (CPT) indicated a resident could live alone with someone checking in weekly. OT-B further stated Medbox was a mock set up of medications and R70 was able to follow instructions and got at least one of the medications correct and was cued on others. OT-B stated you wouldn't use the test to see if a resident can administer their medications, you would look at the overall score and R70's recommendation was monitoring and partial assist for managing medications and stated she thought R70 would be able take medications without staff hovering unless there were notes that indicated R70 could not do that. During interview on [DATE] at 1:16 p.m., the director of nursing, (DON) stated SAM assessments were completed upon admission and with significant changes and additionally worked with OT to get residents set up to go home. DON further stated if a resident had disorientation they would not complete a SAM assessment, however if a resident was alert and oriented times four would be assessed for a SAM. DON further stated she expected R70 to have a SAM and the SAM assessment should have been completed entirely because R70 would still be self administering medications if left at the bedside. 42580 R11 R11's admission Minimum Data Set (MDS) dated [DATE], indicated R11 was cognitively impaired, received antidepressants, opioids, hypoglycemic medications and received hospice cares. R11's care area assessments triggered areas included cognitive loss dementia, visual function, and communication. R11's care plan updated [DATE], lacked a Self Administration of Medication (SAM) assessment documentation. R11's face sheet printed [DATE], included diagnosis of anxiety disorder, restlessness and agitation, attention and concentration deficit. R11's SAM assessment dated [DATE], indicated R11 did not want to self-administer her medications and no further action was needed. R11's physician orders from [DATE], to [DATE], lacked indication for a SAM order. During observation on [DATE] at 2:10 p.m., R11 had two bottles of nystatin 100,000 unit/gram topical powder for candidiasis noted in bathroom sink. One bottle did not belong to R11. R17's nystatin powder was in R11's bathroom sink. There was also a bottle of unlabeled expired aspirin 81 milligrams (mg) in top cabinet bottom shelf in R11's bathroom. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on [DATE] at 11:01 a.m., registered nurse (RN)-G stated nystatin powdered and creams were okay to be kept in resident's rooms so that nursing assistants could apply to resident during provision of care. During observation the following medications were noted in R11's bath basin in cupboard: unlabeled aspirin 81mg, expired on ,d+[DATE], found on top shelf in cupboard; pramoxine-menthol 1.0 .5% lotion, apply topically four times daily for itching, found in bath basin on middle shelf in cupboard; and nystop 100,000 unit per gram, topically two times a day. RN-G verified the medications were in R11's room and left the nystop and pramoxine-menthol lotion in room, then removed the unlabeled expired aspirin 81mg from R11's room, then stated perhaps R11 was admitted with medication or family had brought into facility. During interview on [DATE] at 11:02 a.m., DON stated nystatin powder was to be administered by nurses and were not to be kept in residents' rooms for nursing assistants to administer. DON further clarified all medications should be kept in medication and treatment carts and not in residents rooms. R52 R52's significant change MDS dated [DATE], indicated R52 was cognitively impaired and diagnosis included anxiety disorder, and depression and was given antipsychotics, antianxiety and antidepressants during the assessment period. R52 was also on hospice care. R52's care plan revised [DATE], indicated R52 displayed difficulty in making decisions, declining memory, disorientation and exhaustion. R52's care plan lacked a SAM documentation. R52's diagnosis list printed [DATE], indicated unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hemiplegia (paralysis of one side of the body), and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following unspecified cerebrovascular disease (interruption in the flow of blood to cells in the brain). R52's self-administration of medication assessment dated [DATE], indicated R52 did not want to SAM, with no further assessment needed. R52's physician orders printed [DATE], lacked a SAM order. During observation on [DATE] at 4:55 p.m., R52 was was sitting at the dining table with a medication cup left sitting in front of her with two round white pills noted in cup. R52 stated she thought the medications were Tylenol but did not want to take the medication. The white pills were slightly melted and R52 stated had placed in mouth but did not want to take the medication so had spit them out into the medication cup left at the table. During interview on [DATE] at 5:04 p.m., trained medication assistant (TMA)-B stated had given R52 medications and R52 placed in mouth with water and may have spit out the pills. TMA-B further explained R52 refused cares and medications. During interview on [DATE] at 11:02 a.m., director of nursing (DON) stated when nursing staff administered medications to residents, staff were expected to observe and ensure the resident had taken the medications before leaving resident if resident did not have a SAM assessment which would indicate they could do so independently. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Self Administration of Medications dated [DATE], indicated residents had the right to self administer medications if the interdisciplinary team has determined it is clinically appropriate and safe. The nursing associates will assess each resident's mental and physical abilities to determine whether self administering medications is clinically appropriate for the resident. Assessment is documented in the electronic health record (EHR). The resident has the right to self administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. The IDT considers the following: the medications appropriate and safe for administration, the resident's physical capacity to swallow and open bottles, the resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for, the residents capability to follow directions and tell time to know when medications are needed, the resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to nursing associates, the resident's ability to understand what refusal of medication is and appropriate steps taken by associates to educate when this occurs, the resident's ability to ensure that medication is stored safely and securely.		

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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** 46885 Based on observation, interview and document review, the facility failed to provide timely activity of daily living (ADL) assistance for 2 of 2 residents (R9, R38) who required staff assistance to make it out to meals. Findings include: A form, Meal Times, indicated an open breakfast from 7:30 a.m., until 9:00 a.m., and lunch was served at 11:30 a.m., on the 4th and 5th floors and at 12:00 p.m., on the 3rd floor. Dinner was served at 4:30 p.m., on the 4th and 5th floors and at 5:00 p.m., on the 3rd floor. Forms, NAR Group Sheet 1, NAR Group Sheet 2, NAR Group Sheet 3, indicated the following, mealtime reminder: must count the meal tickets to make sure that all residents have eaten, please reapproach three times and notify the nurse if a resident refuses cares. R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 had intact cognition, did not have physical, verbal, or other behaviors, and did not reject cares, required set up or clean up assistance with eating, substantial to maximum assistance with showering/bathing, partial to moderate assistance with upper body dressing, personal hygiene, and was dependent on staff for lower body dressing, chair to bed and bed to chair transfers, and required substantial to maximum assistance with sitting to standing. R9's physician orders indicated the following order: 12/18/23, RG7 (normal everyday foods of various textures that are developmentally and age appropriate. Biting and chewing ability needed.) regular texture cardiac less than 2400 milligrams (MG) of sodium diet and thin liquids. R9's Face Sheet form dated 4/17/24, indicated R9 had morbid obesity due to excess calories, had chronic kidney disease stage 3, prediabetes, muscle weakness, anxiety, and depression. R9's care plan dated 4/16/24, indicated R9 had a potential for alteration in nutrition and was able to feed himself with meal set up and interventions included: small meal portions to support weight loss per resident wishes, staff to offer salads and saltine crackers with soups at lunch and dinner meals per resident preference. Likes egg, cheese, cucumber and tomato, likes apples, sandwiches, oatmeal, juice, coffee, celery, raspberry vinaigrette dressing, dislikes carrots, provide meal set up. Diet per physician orders, encourage adherence to therapeutic diet per physician orders, encourage good food and fluid intakes at and between meals as needed. R9's care plan dated 4/16/24, indicated R9 had a mobility deficit as evidenced by R9 required assist with mobility and transfers due to increased weakness, deconditioning secondary to congestive heart failure, bilateral lower extremity weakness, obesity and interventions included: provide assistance for mobility while encouraging as much independence as able. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's care plan dated 4/16/24, indicated R9 had a self care deficit in ADLs due to congestive heart failure (CHF), interventions included: assist of one with grooming as needed, extensive assist of one with dressing, and extensive assist with transfers. R9's care sheet indicated R9 was on an RG7, 2200 milliliter (ML) fluid restriction, and preferred hot meals and ice in cold drinks. Additionally, R9 required a mechanical stand lift for transfers, and assist of one for dressing and grooming. During interview on 4/17/24 at 7:24 a.m., dietary aide (DA)-A stated breakfast started at 7:30 a.m., and serving went until 9:00 a.m. During interview on 4/17/24 between 9:32 a.m., and 9:46 a.m., dietary aide (DA)-A verified there were still residents who had not eaten including R9, R50, and R64. During observation on 4/17/24 at 9:54 a.m., R9 was in his room and had not had breakfast. During interview on 4/17/24 at 10:29 a.m., DA-A stated R9 had to come out to the dining room to eat and was normally out by 9:30 a.m., and stated R9 did not receive breakfast because he did not come out to the dining room. During observation on 4/17/24 at 10:32 a.m., R9's door was closed. During observation on 4/17/24 at 10:34 a.m., nursing assistant (NA)-C brought R9 out of his room and wheeled resident down towards the dining room. During interview on 4/17/24 at 10:47 a.m., NA-C stated R9 did not receive any breakfast and R9 liked oatmeal and scrambled eggs however, they were really running behind, but stated she would ask R9 if he wanted toast. During observation on 4/17/24 at 10:52 a.m., NA-C offered toast and R9 stated he did not eat bread and said he would wait until lunch. R9 did not get oatmeal and was not offered oatmeal. During interview on 4/17/24 at 12:58 p.m., NA-C stated when they started the shift, NA-C was working as a trained medication aide (TMA) and there was only two aides, NA-C began working as an NA after an agency nurse came in and R9 did not eat breakfast because they were behind and R9 did not eat meals in his room, nor did he take medications in his room. During interview on 4/17/24 at 1:19 p.m., R9 stated staff got him up about 10:30 a.m., and R9 had to wait until lunch to get something to eat. R9 stated that has happened 3 or 4 times and stated he was hungry and further stated he lived on oatmeal with brown sugar and scrambled eggs, but because it was too late, could not get it and when it waits too long, it is cold and then stated he did not want cold food. R9 stated he liked to be up around 9:00 a.m. During interview on 4/18/24 at 8:21 a.m., NA-C stated R9 required assist with peri care, dressing, and stated they completed most of R9's activities of daily living (ADLs). During observation on 4/18/24 at 9:17 a.m., R9's call light was on and at 9:22 a.m., NA-C went in to R9's room and answered the call light. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/24 at 9:35 a.m., DA-A stated he was finished serving and did not know why R9 and R38 had not received a meal tray. During observation on 4/18/24 at 9:40 a.m., R9 was in bed. During interview on 4/18/24 at 9:41 a.m., NA-L stated she went in to show NA-M R9 and R9 stated he did not want to get up until 9:00 a.m., and NA-M was giving showers and did not know why R9 was still in bed. NA-L further stated at times, some residents were eating breakfast when lunch was being served. During interview on 4/18/24 at 9:54 a.m., NA-C stated she answered R9's light at 9:22 a.m., and asked R9 if he was ready to get up as he told his NA he needed 20 more minutes, and told R9 his aide was finishing a shower. NA-C further stated this group had a lot of residents who required lift transfers and if you were not the regular aide on the group, it was difficult to get the residents up in a timely manner. NA-C further stated R9 mentioned he missed breakfast the day prior and stated she told the dietary aide today that R9 needed scrambled eggs and oatmeal when he got up. During interview on 4/18/24 at 10:03 a.m., NA-M stated she planned to get R9 up, but did not have the care sheet. During interview and observation on 4/18/24 between 10:11 a.m., and 10:13 a.m., R9 was out in the dining room and stated he had just gotten out of bed and was waiting for breakfast. R9 stated he did not like to get up before 9:00 a.m., and at 9:00 a.m., NA-M was giving someone a shower so he had to wait. At 10:13 a.m., NA-M delivered R9 oatmeal and scrambled eggs. R38: R38's quarterly MDS dated [DATE], indicated moderate cognitive impairment, did not have physical, verbal, or other behaviors, and did not reject care, had impairment on one side for upper and lower extremity range of motion, required set up or clean up assistance with eating, partial to moderate assistance with dressing, personal hygiene, and transferring. R38's State Optional Assessment (SOA) dated 2/29/24, indicated R38 ate independently, required extensive assistance with toileting, bed mobility, and transfers. R38's Face Sheet form dated 4/16/24 at 2:48 p.m., indicated the following diagnoses: hemiplegia (one sided paralysis) and hemiparesis (one sided muscle weakness) following cerebral infarction (stroke), dementia, ataxia (poor muscle control) following cerebral infarction, dysphagia (difficulty swallowing) following cerebral infarction, alcohol abuse, other abnormalities of gait and mobility, muscle weakness, other lack of coordination, cerebrovascular disease, and major depressive disorder. R38's care plan dated 4/4/24, indicated R38 had a self care deficit and required assist of two for bed mobility, assist of two for transfers with a hoyer lift, and assist of two with toileting needs. R38's care plan dated 4/11/24, indicated R38 was at risk for falling and a new intervention implemented on 4/11/24, indicated to bring R38 to the dining room at least 30 minutes prior to a meal. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's care plan dated 4/4/24, indicated R38 was non compliant with care needs and refused to donn clothing, eat meals, or change incontinent products. Interventions included: accept R38's right to refuse and show respect for decisions, offer as many alternatives as possible for me to choose from, R38's care plan dated 4/16/24, indicated R38 was potentially at risk for nutrition and hydration needs related to cerebral vascular accident (CVA, stroke), dementia, depression, and alcohol abuse and interventions included: provide three meals per day and offer snacks. R38's care sheet indicated R38 required assist of two for transfers using a hoyer lift, was incontinent of bowel and bladder, required assist of 1 for dressing and grooming and report changes in mood and behavior to the nurse. R38's progress notes dated 11/30/23 at 1:11 p.m., indicated R38 preferred three meals a day and had his meals in the dining room. R38's progress notes dated 12/13/23 at 7:22 a.m., indicated R38 ate three meals a day in the dining room and his appetite was good. R38's progress notes dated 12/29/23 at 3:18 p.m., indicated R38 had non significant weight loss since admission and R38 occasionally would skip one meal per day. R38's progress notes dated 1/19/24 at 1:51 p.m., indicated R38 had a gradual weight loss and encourage resident to be up for breakfast meal in the dining room. R38's progress notes dated 1/19/24 at 9:39 p.m., indicated R38 did not receive a shower due to staff problems. R38's progress notes dated 4/11/24 at 1:23 p.m., indicated R38 had fallen on 4/9/24. R38 stated he was trying to go to the dining room and a new intervention was added that R38 would be brought to the dining room a half hour before meal time. During interview on 4/17/24 at 8:55 a.m., licensed practical nurse (LPN)-A stated staff looked at the care sheets to know what cares a resident required. During observation on 4/18/24 at 8:51 a.m., R38 was in bed. During observation on 4/18/24 at 9:02 a.m., there were eight meal tickets on the counter on the fourth floor including R9, and R38. During observation on 4/18/24 at 9:16 a.m., R38 was in bed. During observation on 4/18/24 at 9:23 a.m., there were 6 meal tickets located on the counter on the fourth floor including R9, and R38. During observation on 4/18/24 between 9:31 a.m., and 9:35 a.m., two meal tickets were located on the counter on the fourth floor for R9, and R38. At 9:32 a.m., DA-A took both tickets into the kitchen. At 9:35 a.m. , DA-A stated he was done serving and did not know why R9 or R38 had not received a meal tray. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/18/24 at 9:40 a.m., R38 was in bed. During interview on 4/18/24 at 9:41 a.m., NA-L stated there were new residents on the floor and as a result their times were getting scrambled and residents want to get up at the same time and stated it was full on this floor. NA-L further stated the aide on R38's group was newer and was learning. NA-L further stated she wanted residents to eat by 9 because lunch came at 11:30 a.m. NA-L stated if it was past 10:30 a.m., she would ask a resident if they wanted a snack and would try to make sure they received lunch first. During interview on 4/18/24 at 9:54 a.m., NA-C stated she did not know if NA-M had gone into R38's room or if she offered to get R38 up. NA-C further stated NA-M's group had a lot of resident's who required a mechanical lift and if you were not the regular person on the group, it was difficult to get the residents up in a timely manner. NA-C further stated it was not ok to miss breakfast. During interview on 4/18/24 at 10:00 a.m., NA-C stated now that she was finished with a.m., medications she would offer her help with R38. During interview on 4/18/24 at 10:03 a.m., NA-M stated R38 was not refusing to get up, she had just not gotten to him. During observation on 4/18/24 from 10:14 a.m., to 10:17 a.m., NA-N took the full body mechanical lift out of R38's room and at 10:17 a.m., NA-C pushed R38 out to the dining room. During interview and observation on 4/18/24 between 10:23 a.m., and 10:31 a.m., at 10:24 a.m., NA-C brought R38 [NAME] toast and R38 stated he was hungry. NA-C stated she brought R38 toast with butter and strawberry kiwi juice. At 10:25 a.m., R38 began eating his toast. R38 had two pieces of toast cut in half and was finished eating his toast by 10:31 a.m. During interview on 4/18/24 at 11:23 a.m., the registered dietician (RD)-H stated R38 should have three meals a day and sometimes skipped breakfast per his choice depending on what time he got up. RD-H further stated if a resident wanted to get out of bed and was not getting help, it was not acceptable to miss breakfast. RD-H further stated their culinary staff relied on nursing staff to get residents out of bed and their staff had to wait until the resident was out in the dining room. During interview on 4/18/24 at 12:27 p.m., licensed practical nurse (LPN)-A stated R9 liked to get up at 9:00 a.m., but with the amount of people that have to care for R9 sometimes R9 was not up at a perfect time which was a terrible fact and stated it was not acceptable. LPN-A further stated normally NA-I was R9's aide and if R9 wanted to be up at 9:00 they should have made sure it got done. LPN-A further stated they wanted residents up and eating breakfast with their peers and needed to come up with better time management and further stated R38 should not have just received toast. During interview on 4/18/24 at 1:30 p.m., the director of nursing stated on 4/17/24, they were short staffed due to a call in and got people to come in, however it was later in the morning and further stated it was important to get ADLs in order to maintain healthy nutrition and hydration and expected residents get up for meals or could have brought meals to residents in their room. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/24 at 2:29 p.m., the culinary director (CD) stated the facility provided three meals, breakfast, lunch, and dinner and a meal consisted of a protein, a starch, a dessert and a vegetable and toast was not considered a meal. A policy, Activities of Daily Living (ADL) dated June 2021, indicated the purpose of the policy was to provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out ADLs. Residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility. If residents with cognitive impairment or dementia exhibit behavioral expressions of resistance to cares, associates will attempt to identify the underlying cause of the problem and not assume the resident is declining or refusing care. Approaching the resident in a different way, or at a different time, or having another associate speak with the resident may be appropriate.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to provide timely referral to an outside optometry service to resolve broken eyeglasses and provide a routine follow up appointment for 1 of 1 resident (R9) reviewed whose glasses were broken. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 had intact cognition, had adequate vision including fine detail, including regular print in newspapers and books with glasses or other visual appliances and did not wear corrective lenses. R9's annual MDS dated [DATE], indicated R9 had adequate vision and wore corrective lenses, and it was very important to have books, newspapers, and magazines to read. R9's state optional assessment dated [DATE], indicated R9 required extensive assist for bed mobility, transfers, and toileting and was independent with eating. R9's progress notes were reviewed on 4/17/24 at 2:59 p.m., and lacked documentation of any refusals of eye exams after 8/22/22. R9's care plan dated 4/16/24, indicated R9 wellness would provide R9 with reading materials and puzzles. R9's care plan dated 4/16/24, indicated R9 could read regular print with glasses and had a history of vitreous detachment (vitreous is the gel like fluid that fills your eye and contains fibers that attach to the retina. Fibers of the vitreous pull away and can cause symptoms that can affect vision) and saw a specialist. Interventions indicated to arrange eye appointments and rides as requested by resident and family, assure that the lenses of glasses were clean and in good repair, observe for signs or symptoms of decreased visual acuity like statements of vision changes, squinting at TV, not being able to identify objects and staff etc and update as needed. A form, Quality Healthcare Services Provided On-Site with Compassion and Care provided by the facility indicated Healthdrive's health professionals brought dental, optometry, podiatry and audiology services directly to residents of extended care facilities. Optometry provided glaucoma and overall eye health testing, vision testing using trial lenses specialized for the elderly, eyeglass fabrication, repair and engraving, and low vision aids for the partially sighted. R9's HealthDrive form dated 10/28/20, indicated R9 consented to be seen for audiology, eye care, and podiatry. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's HealthDrive Eye Care Group form dated 10/3/22, indicated R9 had a macular scar on the right eye, pseudophakia (artificial lens implant), low vision on the right and normal vision on the left, and presbyopia (age related far sightedness). Under the heading, Plan indicated monitor, follow up comprehensive on 9/27/23, and new reading eyeglasses; new glasses improve vision, patient defers bifocal. Under the heading, Action indicated R9 required glasses and staff were to encourage part time use for reading. R9's HealthDrive Eye Care Group form dated 12/20/22, indicated R9's glasses were adjusted and under the heading, Plan indicated monitor; follow up comprehensive on 9/27/23. Further, glasses were required and staff were to encourage part time use for reading. During interview on 4/15/24 at 6:03 p.m., R9 stated the temple part of his eyeglasses had been broken for about a year and R9 wanted to get new glasses because he couldn't see to use his computer and stated the facility had not set up an appointment for him to be seen. During interview and observation on 4/17/24 at 10:43 a.m., nursing assistant (NA)-C brought R9 out of his room and R9 did not have any glasses on. NA-C stated R9 had glasses with him. During interview and observation on 4/17/24 at 1:19 p.m., R9 took out eyeglasses in a brown case and they were missing the temple and R9 further stated the eyeglasses he currently wore had a horizontal line across the lens and did not like to wear those because it made it difficult for him to see his puzzles. R9 stated he had an additional pair of glasses and observed the pair and the temple was pulled out all the way to the side. R9 stated he wasn't able to read the computer because he did not have glasses to see with. During interview on 4/17/24 at 11:05 a.m., the director of nursing stated HealthDrive came to the facility but was not sure if optometry came and added someone came for vision and the health information manager (HIM) handled appointments. During interview on 4/17/24 at 1:37 p.m., the HIM stated the facility used a service called HealthDrive that provided dental, audiology, optometry, and podiatry services. HIM further stated optometry usually came to the facility about three times a year. When a resident is admitted, residents are provided a form they complete before they are seen to indicate the services wanted. HIM verified R9 had requested eye care and stated R9's last appointment was on 12/21/22 and further added appointment refusals were documented in the progress notes and HIM verified there were no documented refusal in the progress notes. HIM further stated everyone received a HealthDrive form to sign or decline services but the social worker (SW) followed up. HIM further stated optometry was last at the facility January 4th or 5th 2024. During interview on 4/17/24 at 2:19 p.m., SW-A stated she had been working at the facility about two months and was starting to complete components of the MDS, but did not complete the vision or hearing section. SW-A further stated the previous SW quit working at the facility about two weeks prior. During interview on 4/17/24 at 2:24 p.m., registered nurse (RN)-D stated she completed section B of the MDS which contained information on vision based on clinical documentation and observations. RN-D further stated HealthDrive was discussed at care conferences and the SW would follow up with the resident and stated she expected R9 to have an eye appointment if a follow up appointment was ordered. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/17/24 at 2:36 p.m., the director of nursing (DON) stated HIM managed HealthDrive and either the manager or SW asks if residents want the service and obtain consent and then the HIM manages the visits. DON further stated if a resident refused an appointment, HealthDrive would document the refusal and it would be scanned in the electronic medical record (EMR). DON further stated it sounded like R9 should have had an eye appointment if the form indicated a follow up and would look for a policy. During interview on 4/18/24 at 1:21 p.m., the DON stated R9 was not seen by optometry because the eye doctor was on maternity leave and they planned to talk with R9 to see if he wanted to be seen or have his glasses fixed. A policy was not provided.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure interventions were in place for 1 of 3 residents reviewed for pressure ulcers. Findings include: R183's Brief Interview & Staff Assessment for Mental Status (BIMS) dated 4/9/24, indicated R183 had moderate cognitive impairment. R183's Continuity of Care document printed 4/18/24, indicated R183's diagnoses included pressure ulcer of right heel and lymphedema. R183's Functional Abilities assessment dated [DATE], indicated R183 required substantial/maximal assistance with putting on/taking off footwear and sit to stand performance. R183's admission body audit/skin condition assessment dated [DATE], indicated R183 had a right heel wound. R183's Skin Risk Observation with Braden Scale dated 4/8/24, indicated R183 had an unhealed pressure injury on right lower heel and at risk for further skin breakdown. The assessment identified interventions which included heel protectors. R183's provider orders included the following: 4/8/24-Out of bed-CAM boot on right foot anytime out of bed to offload wound and protect foot. In bed-heel protector boots on, place pillows under legs also to help offload heels. 4/10/24-Zflex offloading boots (heel protector boots) while in bed to fully offload heels. Z-Flex boot (CAM) on right foot while up in wheelchair. Goal to keep all pressure off heels and off the wound. 4/10/24-Tubi grips on BLE (bilateral lower extremities) daily. On in AM and off at HS (bedtime). R183's care plan (CP) dated 4/16/24, indicated R183 was at risk for alteration of skin status d/t (due to) lymphedema, and skin impairment to right heel. CP interventions included tubi grips and z-flex boots as ordered. R183's undated nurse aide care sheet indicated, Tubi grips on in AM & off @HS and Z-flex boots when in bed. CAM boot on for transfers. During observation and interview on 4/15/24, at 5:58 p.m., R183 was sitting in wheelchair in room. R183 did not have the tubi grips or the CAM boot on and had both feet resting flat on the floor. The CAM boot was on the floor next to the dresser and the Z-flex boots were on the windowsill. No tubi grips observed. R183 stated staff were not applying those boots when in bed but used the CAM boot to walk. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/16/24 at 1:55 p.m., R183 was not in room. Z-flex boots sitting in windowsill in same position as previous day. During observation and interview on 4/17/24 at 6:57 a.m., R183 was up and dressed and sitting in wheelchair. The CAM boot was sitting on the floor by the dresser. During interview on 4/17/24 at 7:24 a.m., R183 stated she did not have the z-flex boots on overnight, legs were not elevated with pillows and heel rested directly on the bed. R183 stated she had not had the CAM boot on yet today and had transferred without it. R183 stated they typically did not put the CAM boot on until after wound care which was supposed to be in the morning but occasionally did not occur until after noon. The z-flex boots remained in the windowsill in the same previous position and the CAM boot was on the floor by the dresser. R183 did not have wraps or tubi grips and stated staff had never used any compression items on her legs since admission. R183's feet were resting directly on the floor. During interview on 4/17/24 at 7:42 a.m., registered nurse (RN)-A stated R183 should have pressure reducing boots on at all times while in bed and the CAM boot on when up in the wheelchair. RN-A further stated R183's heel should be protected from further breakdown with pillows or boots and should not be resting on the ground. During interview on 4/17/24 at 8:19 a.m., nursing assistant (NA)-B stated R183 did not have any boots on while in bed this morning nor when assisted into the wheelchair. During interview on 4/17/24 at 8:44 a.m., NA-A verified and stated R183 was sitting up in wheelchair and did not have the CAM boot on and was not wearing tubi grips. During interview on 4/17/24 on 11:17 a.m., RN-B stated R183's heel should always be protected either with soft z-flex boots while in bed or CAM boot when out of bed. RN-B stated R183 required the CAM boot for all transfers. RN-B further stated R183 should have tubi grips applied in the morning and removed at night and that the NAs could do it and nursing would verify and document completion. During interview on 4/17/24 at 11:21 a.m., wound doctor (WD) stated expected R183 would have offloading boots while in bed and a CAM boot for transfers. During interview on 4/18/24 at 9:25 a.m., occupational therapy assistant (OT)-A stated expectation for R183 to have CAM boot on for all transfers. During interview on 4/18/24 at 12:06 p.m., director of nursing (DON) stated expectation for pressure ulcer interventions to be implemented as ordered. Facility policy Prevention and Treatment of Skin Breakdown/Pressure Injury undated, indicated, residents at an increased risk for impaired skin integrity are provided preventative measures to reducing the potential for skin breakdown. Those residents who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care.		

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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** 46885 Based on observation, interview, and document review, the facility failed to ensure use of a bed pan and urinal were offered and in place for 1 of 2 residents (R38) in accordance with the individualized care plan. Findings include: R38's quarterly Minimum Data Set (MDS) dated [DATE], indicated mild cognitive impairment, did not have behaviors, did not reject cares, had upper and lower extremity impairment on one side, required supervision or touching assistance for toileting hygiene, partial to moderate assistance with upper and lower body dressing, personal hygiene, was not on a toileting program for bowels or bladder, and was frequently incontinent of bladder and bowel. R38's Face Sheet form dated 4/17/24, indicated R38 had the following diagnoses: hemiplegia (paralysis on one side of the body) and hemiparesis (weakness) following cerebral infarction (stroke) affecting the left non dominant side, unspecified dementia, ataxia (lack of muscle coordination) following cerebral infarction, dysphagia (difficulty swallowing) following cerebral infarction, constipation, weakness, epilepsy, and diarrhea. R38's care plan dated 4/4/24, indicated R38 had functional urinary incontinence and interventions included: check and change incontinent products every three hours, ensure adequate bowel elimination per facility, have urinal within reach at the bedside, use incontinent products as needed. R38's care plan dated 4/4/24, indicated R38 had a self care deficit and required assist of 1 for bathing, assist of 2 with bed mobility, assist of 2 for transfers using a full body mechanical lift, was incontinent of bowel and bladder, and had a bowel and bladder plan that will help remain free of skin breakdown and respect R38's dignity, required assist of two for toileting needs. R38's care sheet indicated R38 was incontinent of bowel and bladder and intervention under bladder indicated offer the bed pan if preferred, check and change every three hours while awake and at night, document all bowel movements. The care sheet lacked information having a urinal at the bedside. During interview and observation on 4/15/24 at 12:59 p.m., R38 stated he went into the bathroom when he had to use the bathroom. A bed pan was located in the bathroom sitting on the toilet riser. During interview on 4/15/24 at 5:15 p.m., family member (FM)-G stated because of R38's stroke, staff told R38 to go in his depends. During interview and observation on 4/16/24, at 1:33 p.m., R38 was in bed and a urinal was located on the back of the toilet and stated staff did not help R38 in the bathroom, they provide a bedpan to use. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/16/24 at 1:39 p.m., nursing assistant (NA)-I stated they looked at care sheets to know what kind of a cares a resident required, however did not have her care sheet on her and stated she could grab a care sheet. NA-I viewed R38's care sheet that indicated offer bed pan if preferred and stated R38 had been continent and asked for the urinal and bed pan and further stated she had R38 ask for the urinal instead of keeping it at the bedside and assisted R38 and stated R38 could take the bed pan out from underneath him and had not had any episodes of incontinence that day. During observation on 4/17/24 at 7:10 a.m., R38 was in bed and there was no urinal located at the bedside. A brief was located on the floor next to the bed. During interview and observation on 4/17/24 between 7:53 a.m., and 8:12 a.m., NA-J picked up the brief off the floor and placed it in the garbage and grabbed a new brief. The urinal was located on top of the toilet. R38 was in bed. NA-J told R38 she was going to get him dressed and assisted in applying a brief. At 7:56 a. m., NA-J had R38 turn to the side and R38 had a smear of stool and NA-J wiped R38's bottom. NA-J did not offer R38 a bedpan or urinal. NA-J continued to wipe R38's bottom that had smears of stool and applied the new brief. At 7:59 a.m., NA-J assisted in donning R38's pants and placed a sling under R38. At 8:04 a.m., NA-C came into the room to assist with a full body mechanical lift transfer and at 8:08 a.m., R38 was transferred into his wheelchair. At 8:12 a.m., R38 was wheeled out to the dining room. The bedpan and urinal were not offered. During interview on 4/17/24 at 8:55 a.m., licensed practical nurse (LPN)-A stated staff looked at care sheets to know what cares a resident required and the care sheets were updated where there was a change in the plan of care. LPN-A viewed R38's care sheet and stated R38 was incontinent and used a bed pan and required a check and change every three hours. LPN-A stated she expected staff to offer a bed pan if preferred. LPN-A further verified the care sheet did not indicate the urinal was to be at the bedside and stated it should have been on the care sheet and further stated staff would not know to place the urinal at the bedside because it was not indicated on the care sheet. During interview on 4/17/24 at 10:22 a.m., NA-J stated she usually looked at the care sheet, and finds an NA who worked regularly and asks them to go through every person. NA-J stated R38's care sheet indicated to offer the bed pan and verified she did not offer the bed pan to R38 and stated R38 took his own brief off and she should have offered the bed pan and did not know R38 required the urinal at the bedside. During interview on 4/18/24 at 1:23 p.m., the director of nursing stated she expected the urinal be at R38's bedside. A policy was requested related to bowel and bladder care.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview, observation, and document review, the facility failed to provide a therapeutic diet as prescribed and failed to ensure adequate hydration in accordance with the individualized care plan for 1 of 2 residents (R38). Findings include: R38's quarterly Minimum Data Set (MDS) dated [DATE], indicated mild cognitive impairment, did not have behaviors, did not reject cares, had upper and lower extremity impairment on one side, required supervision or touching assistance for toileting hygiene, partial to moderate assistance with upper and lower body dressing, personal hygiene, and required set up or clean up assistance for eating. The MDS further indicated R38 was on a therapeutic diet. R38's Face Sheet form dated 4/17/24, indicated R38 had the following diagnoses: hemiplegia (paralysis on one side of the body) and hemiparesis (weakness) following cerebral infarction (stroke) affecting the left non dominant side, unspecified dementia, ataxia (lack of muscle coordination) following cerebral infarction, dysphagia (difficulty swallowing) following cerebral infarction, weakness, and diarrhea, and hyperlipidemia (an excess of lipids or fats in the blood that can increase your risk of a heart attack or stroke) R38's physician's orders indicated the following orders: 11/24/23, low sodium, low fat RG7 (normal everyday foods of various textures that are developmentally and age appropriate. Biting and chewing ability is needed) regular texture diet. 11/24/23, thin liquids. 2/5/24, weekly weight on Mondays. 2/26/24, ReadyCare shake (chocolate) 4 ounces (oz) daily every a.m., document amount consumed for weight loss. 2/26/23, Offer snacks twice daily, document the amount consumed. R38 prefers: yogurt, chocolate pudding, cheese crackers, peanut butter crackers at 2:00 p.m., and 8:00 p.m. R38's care plan dated 4/4/24, indicated R38 required assist of two for bed mobility and transferred using a hoyer lift with two assist. R38's care plan dated 4/11/24, indicated R38 was at risk for falling and interventions included to bring R38 to the dining room at least 30 minutes prior to a meal. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's care plan dated 4/16/24, indicated R38 was at risk for nutrition and hydration needs due to a diagnoses of cerebrovascular accident (CVA) (stroke), dementia, alcohol abuse and depression. R38 is able to feed himself and voice needs after set up assistance. R38's interventions included: offering Mrs Dash and pepper with meals, offer snacks twice a day (yogurt, chocolate pudding, cheese and crackers, peanut butter crackers), weights once a day on Wednesdays, offer 30 to 60 cubic centimeters (cc's) by mouth fluids with every contact, R38 prefers water and Ginger Ale, R38 is provided with three meals a day and snacks are offered. R38's care sheet indicated R38 was on a heart healthy RG7 diet, had an adaptive cup with a lid, and R38 required a bedtime snack and enjoyed peanut butter and jelly sandwiches, required assist of 1 to 2 for bed mobility and assist of two with a hooyer lift for transfers. A weekly menu for week 1 dated Monday 4/15/24, through Sunday 4/21/24, indicated the following meals: 4/16/24, 2% milk, oatmeal, diced peaches, scrambled eggs, bacon, strudel cherry stick or vanilla yogurt, cheerios, dry wheat toast. 4/16/24, chicken florentine herbed penne pasta, meadow blend vegetables, mint chocolate chip ice cream or salami sandwich, multigrain sunchips, meadow blend vegetables, bean and bacon soup. 4/17/24, eggs [NAME], chilled fruit cocktail, oatmeal, 2% milk, or vanilla yogurt, corn flakes, and dry wheat toast. R38's meal ticket for breakfast 4/16/24, indicated the following under the heading Diet cardiac 2 gram, regular texture, and thin liquids. Under the heading, Beverage indicated decaf coffee, and under the heading, Dairy indicated skim milk and vanilla yogurt. Under the heading, Juice indicated orange juice. Under the heading, Cereal indicated cheerios and oatmeal. Under the heading, fruit indicated diced peaches. Under the heading, Entree indicated scrambled egg. Under the heading, Breakfast sides indicated hard boiled egg, under the heading, Bread indicated dry wheat toast and buttered raisin toast, and under the heading, Condiment indicated Mrs Dash seasoning, pepper, and grape jelly. R38's meal ticket lacked bacon or strudel cherry stick as a meal option. R38's meal ticket for lunch on 4/16/24, indicated under the heading, Beverage decaf coffee, under the heading, Dairy indicated skim milk, under the heading, entree indicated chicken florentine or beef deli sandwich on wheat. Additionally, under the heading, Starch indicated multigrain sunchips or herbed penne pasta, under the heading, Vegetable indicated meadow blend vegetables, under the heading, Condiment indicated pepper or Mrs Dash seasoning, and under the heading, Dessert indicated vanilla ice cream and under the heading, Soup indicated chicken noodle soup. R38's meal ticket lacked a salami sandwich as a meal option. R38's meal ticket for breakfast on 4/17/24, indicated under the heading, Beverage decaf coffee, under the heading, Dairy indicated skim milk or vanilla yogurt. Under the heading, Juice indicated apple juice, under the heading, Cereal indicated corn flakes or oatmeal, under the heading, Fruit chilled fruit cocktail, under the heading, Entree indicated egg muffin sandwich, under the heading, Bread indicated dry wheat toast, and under the heading, :Condiment indicated pepper, grape jelly, and Mrs Dash seasoning. The meal ticket did not indicate eggs [NAME] as a meal option. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's progress notes dated 11/25/23 at 4:27 p.m., indicated family member (FM)-G wanted R38 on a heart healthy diet. R38's progress note dated 11/30/23 at 1:11 p.m., indicated R38 preferred three meals a day, ate in the dining room and was able to feed himself and like a bedtime snack. R38's weight was 176.4 pounds on 11/27/24. R38's progress note dated 12/13/23 at 7:22 a.m., documented as a late entry on 12/14/23 at 7:22 a.m., indicated R38 at three times a day in the dining room and was offered a snack at night. R38's weight was 175 pounds and dietary reported R38 was on a heart healthy diet related to CVA. R38's progress note dated 12/28/23 at 8:31 a.m., indicated the snack order was updated to offer twice a day snacks per family preference. R38's progress note dated 1/3/24 at 2:04 p.m., indicated R38 required a cup with a lid or other adaptive cup for hot liquids. Additionally, the note indicated R38 had non significant weight loss since admission and occasionally skipped 1 meal per day. A new order for a Readycare Shake 4 oz daily was received to assist in meeting nutritional needs. R38's progress note dated 1/19/24 at 1:51 p.m., indicated R38 had gradual trending weight loss and R38's weight was 168.6 on 1/18/24. Additionally, the note indicated to encourage R38 to be up for breakfast and the previously offered snack twice daily p.m. and bedtime was changed to bedtime only as R38 would receive a supplement in the afternoon. R38's progress note dated 1/26/24, indicated R38 had a care conference and the dietary department reported R38 was on a heart healthy diet of low saturated fat, low salt, blander type diet, and needed assistance with options at meal time. R38's progress note dated 2/26/24 at 3:13 p.m., indicated R38 was offered Readycare shake twice a day due to a history of weight loss and a bedtime snack was offered daily. The supplement and snack order was updated to offer the Readycare shake once daily in the a.m., and a snack twice a day at 2:00 p.m., and at 8:00 p.m. per R38 and family request. R38's progress note dated 4/11/24 at 1:23 p.m., indicated R38 had fallen on 4/9/24, R38 stated he was trying to go to the dining room and a new intervention was added to bring R38 to the dining room half an hour before meal time. R38's vulnerable adult report dated 12/15/23 at 9:34 a.m., indicated the facility was not providing enough water for R38. FM-G was concerned R38 would have another stroke if he became too dehydrated. During observation on 4/15/24 at 12:57 p.m., R38 was in bed and a water pitcher was located on the left side of the window sill and on the opposite side of the window the bed was located, and was out of R38's reach. During interview on 4/15/24 at 5:20 p.m., family member (FM)-G stated R38 relied on staff to bring him out to the dining room and stated R38 was provided the wrong food and stated a heart healthy diet included not having salt. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 4/16/24 between 1:33 p.m., and 1:39 p.m., R38 was in bed and stated he asked someone for water but they left the room. R38 had a maroon pitcher with a black covered water pitcher with a straw on the left side of the window sill. R38 stated he had a sandwich for lunch and chips. At 1:39 p.m., a staff person came in and asked R38 if he wanted his sun chips and R38 said to leave the chips. During interview on 4/16/24 between 1:39 p.m., and 1:51 p.m., nursing assistant (NA)-I stated R38 did not get up for lunch because he was pushing himself out of the chair. NA-I stated R38 had toast, bacon, and a Danish cherry strudel for breakfast and did not want cheerios. NA-I further stated residents had menus and could pick what they wanted to eat. NA-I further stated they looked at care sheets to know what kind of cares a resident required, but did not have a care sheet with her. NA-I viewed R38's care sheet and stated R38 was on a heart healthy diet and stated she passed snacks and water at the end of the shift. NA-I further stated today was sandwich day and R38 received a salami sandwich for lunch because he didn't like chicken. NA-I further stated a heart healthy diet meant R38 used MRS Dash and stated R38's liquids should be at the bedside on the bedside table. At 1:51 p.m., NA-I stated R38's water pitcher should be at his bedside and verified the water pitcher was located out of R38's reach on the left side of the window sill and stated that the water pitcher was from yesterday. NA-I took the pitcher out of the room and replaced the water pitcher with a new pitcher and placed it on the bedside table. During interview and observation on 4/17/24 at 7:53 a.m., NA-J stated she worked for an agency staffing company and told R38 she was going to get him up. R38's water pitcher was located on the bedside table. At 8:02 a.m., NA-J asked R38 if he wanted eggs [NAME] and R38 stated oatmeal was better than a poached egg. At 8:04 a.m., NA-C came in to assist with a hooyer transfer and at 8:08 a.m., R38 was transferred into his wheelchair and at 8:12 a.m., R38 was brought out to the dining room and was not offered water. R38 was not offered a choice of meal in accordance with his meal ticket. During interview on 4/17/24 at 8:55 a.m., licensed practical nurse (LPN)-A stated NA's looked at care sheets to know what cares a resident required. During interview on 4/17/24 at 10:22 a.m., NA-J stated she usually looked at a care sheet and found an aide who worked regularly to know what cares a resident required and stated she worked with R38 before and stated it got hectic when they were busy. NA-J stated she did not offer R38 anything to drink during cares and stated she didn't know she was supposed to give R38 anything to drink. During interview on 4/17/24 at 10:55 a.m., LPN-A stated she expected the care sheet reflect the care plan and offering fluids should have been on the care sheet and stated staff knew to offer R38 water. LPN-A further stated it would be important to be on the care sheet because the facility staffed with agency staff who would need to know how to care for a resident and expected R38's water pitcher to be within reach especially when R38 can not get up and reach it himself and stated she would update the care sheet. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/24 at 11:23 a.m., the registered dietician (RD)-H stated she managed the menus which were on a 5 week cycle and additionally had a fall/winter menu and had just switched to a spring/summer menu. RD-H stated a therapeutic diet consisted of a resident on a heart healthy or diabetic diet and made sure if a menu included for example lasagna, that there is a heart healthy option. If a resident was on a low salt and low fat diet, there was a spreadsheet for the cook if they needed an alternate option. RD-H stated if they had bacon for breakfast they would need to swap the bacon out for heart healthy options and would switch to another protein. RD-H also stated she would not give a resident salami if they were on a low salt and low fat diet. RD-H further stated she would not be as restrictive with therapeutic diets for a resident in long term care if they asked for a salami sandwich, however it would not be on their menu. RD-H further stated residents had a meal ticket every meal and had their diet order and all their meal options so nursing staff would not need to know their options because it was already changed for a resident on therapeutic diet. RD-H stated R38 was on a heart healthy diet because he had a stroke and his family wanted him to be on a heart healthy diet. RD-H further stated on 4/16/24, R38's menu did not indicate he should have salami and stated R38 did not like chicken. RD-H stated it would be important to follow a low sodium diet because R38 had a stroke and his family was adamant R38 receive a heart healthy diet and R38 came to the facility on a heart healthy diet. RD-H stated if it happened frequently where a resident deviated from their diet it would be documented and stated she told residents if they don't like the food they can look to liberalize the diet otherwise could offer Mrs Dash and pepper. RD-H further stated R38's menu indicated he received extra condiments which was done instead of changing R38's diet order. RD-H stated there was nothing in the care plan to deviate from the diet nor was there documentation that R38 was noncompliant with his diet orders and stated she had not heard this week R38 was not compliant with his diet. RD-H further stated R38's menu matched the heart healthy diet and staff should present R38's menu and ask R38 what he wanted and if R38 deviates from his ordered diet, expected a progress note documented. During interview on 4/18/24 at 12:09 p.m., LPN-A stated she expected staff follow orders for a low salt, low fat diet and if R38 was not following the ordered diet, it should be documented. LPN-A stated resident's have rights, but added they should be aware so they can talk to the resident and the physician to see what can be done for the residents and stated bacon was not heart healthy, nor was a salami sandwich. During interview on 4/18/24 at 1:23 p.m., the director of nursing stated she expected R38's water pitcher be next to him and stated she took off the care plan to offer fluids and if R38 was deviating from his diet, they could look at a waiver. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Diet Orders, dated 2012, indicated based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet, prepared in a form designed to meet individual needs, prescribed by the attending physician, when there is a nutritional problem. Each resident will receive and consume foods in the appropriate form and or the appropriate nutritive content as prescribed by a physician and or assessed by the interdisciplinary team to support the treatment and plan of care. Therapeutic diet is defined as a diet ordered by a physician as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in diet, e.g. sodium, or to increase certain substances in diet e.g. potassium or to provide food the resident is able to eat e.g. mechanically altered diet. Substitutes are offered of similar nutritive value to residents that refuse food served. When a diet order does not correspond with the facility's approved diet order terminology, the licensed nurse will be responsible for obtaining clarification from the physician. The diet order is communicated in writing from nursing to culinary services and must correspond with the physician's order as recorded in the medical record. A policy, Resident Noncompliance With Provider Ordered Diet, dated 2012, indicated the resident has the right to refuse treatment, including acceptance of prescribed diet. All foods provided by the community will be consistent with the resident's ordered diet. Resident rights in choice will be upheld. The nursing staff and dietitian or designee will manage noncompliance with the provider ordered diet. When a resident consistently requests food not included in their therapeutic diet, a licensed nurse and or dietitian will explain the potential risk of not adhering to the provider ordered diet. The dietitian or designee will attempt to offer food substitutes that are agreeable to the resident and consistent with their diet ordered. Nursing and dietitian will document in the medical record the foods that the resident chooses to eat, including a discussion of risk and the attempts made to find food acceptable to the resident. The provider physician will be notified to explain resident noncompliance and discuss liberalizing the diet order.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to provide sufficient staffing to ensure residents received care and assistance they needed. This had the potential to affect all 82 residents who resided in the facility. Findings include: The 2023 Annual Facility Assessment updated October 2, 2023, indicated the facility could serve 90 residents and had an average census of 73 residents. The service and care offered based upon the needs of those served included activities of daily living (ADL) support, bowel and bladder care and toileting support, coordination of care with physician and other health care providers, end of life care, fall prevention, infection prevention, medication administration, mobility assistance, nutrition support and pain management. Additionally, had an average of 24 FTE (full time equivalent) nursing staff at full census/pay period including the director of nursing (DON), assistant DON (ADON), clinical managers, Minimum Data Set (MDS) nurse, licensed nurses, infection preventionist, and wound certified nurse; and had 28 FTE nursing assistants, trained medication aide (TMA), and restorative aides. Under the heading, Staffing Plan staffing was planned in advance and altered based upon census in all departments. In addition staffing in nursing and therapy were altered based upon resident need and the number of admission and discharges and agency staff was utilized on an as needed basis. A Daily Census Report dated 4/15/24, indicated the total in house census was 82 residents with one resident on hospital leave. Forms, NAR Group Sheet 1, NAR Group Sheet 2, NAR Group Sheet 3, indicated the following, mealtime reminder: must count the meal tickets to make sure all residents have eaten, please reapproach three times and notify the nurse if a resident refuses cares. The NAR Group Sheets were reviewed and indicated on NAR Group Sheet 1 on the fourth floor there were a total of 10 residents; 4 residents who required an EZ stand, 2 residents who required a Hoyer lift with two assist. On NAR Group Sheet 2 on the fourth floor, there were a total of 10 residents; 3 residents required an EZ stand, one of those residents required two assist to transfer with the EZ stand, and 1 resident who required a Hoyer lift with two assist. NAR Group Sheet 3 on the fourth floor indicated there were 10 residents; 1 resident required an EZ stand for transfers and one residents required assist of two for transfers. A color coded Daily Nursing Schedule form was provided for 4/15/24 through 4/19/24. At the top of the form indicated the following, Going forward all floors will be taking turns on being short on a.m. shift due to call ins. 3rd>4th>5th Today's turn: COB {charge of building} to assign based on previous shift over wknds/holiday. A copy of Daily Nursing Schedule forms were provided from 3/17/24 through 4/17/24. The schedules indicated it was the 4th floor's turn to be short on the a.m. shift due to call ins on the following dates: 3/18/24 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/19/24 3/20/24 3/21/24 3/23/24 3/25/24 3/26/24 3/27/24 4/5/24 4/6/24 4/9/24 4/15/24 4/16/24 4/17/24 A color coded Daily Nursing Schedule form dated 4/15/24, indicated the following: 3rd floor had one 6:30 to 2:30 nursing assistant (NA) shift open. Additionally, the 3rd floor had one agency staff registered nurse (RN) scheduled on the day shift and two agency staff, an RN and licensed practical nurse (LPN) scheduled on the p.m. shift. 4th floor did not have an open shift and had 1 agency RN scheduled on the a.m. shift and one agency trained medication aide (TMA) scheduled on the p.m. shift, and one agency NA scheduled on the night shift. 5th floor did not have an open shift and had two agency nursing assistants scheduled on the a.m. shift, one agency TMA scheduled on the p.m. shift, and one agency RN on the night shift. 5 staff picked up a shift on the 4/15/24 schedule. A color coded Daily Nursing Schedule form dated 4/16/24, indicated the following: 3rd floor had one agency RN scheduled on a.m. shift. 4th floor had one agency LPN scheduled on the a.m. shift, one agency RN and one agency LPN scheduled on the p.m. shift. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5th floor had one agency NA scheduled on the a.m. shift, one agency TMA scheduled on the p.m. shift and one agency NA scheduled on the p.m. shift, and one agency RN scheduled on the night shift. 7 staff picked up a shift on the 4/16/24 schedule. A color coded Daily Nursing Schedule form dated 4/17/24, indicated the following: 3rd floor had one open NA shift on the a.m. shift. 4th floor had one agency TMA scheduled on the a.m. shift. 5th floor had one agency NA on the a.m. shift, one agency TMA scheduled on the p.m. shift. 9 staff picked up a shift on the 4/17/24 schedule. A color coded Daily Nursing Schedule form dated 4/18/24, indicated the following: 3rd floor had one open NA shift on the a.m. shift, one open NA shift on the p.m. shift, and one agency nurse scheduled on the p.m. shift. 4th floor had one open NA shift, one open NA shift on the p.m. shift, and had one agency TMA scheduled on the p.m. shift. 5th floor had one agency TMA on the p.m. shift. 4 staff picked up a shift on the 4/18/24 schedule. A color coded Daily Nursing Schedule form dated 4/19/24, indicated the following: 3rd floor had one open NA shift on the a.m. shift and one open NA shift on the p.m. shift. Additionally, one agency nurse scheduled on the a.m. shift, and two agency nurses scheduled on the p.m. shift. 4th floor had one open NA shift on the p.m. shift and had one agency nurse on the a.m. shift and two agency NA's scheduled on the a.m. shift. 5th floor had one open shift on the a.m. shift and had one agency nurse scheduled on the a.m. shift, and one agency nurse scheduled on the night shift. 2 staff picked up a shift on the 4/19/24 schedule. Refer to F677: the facility failed to provide timely activity of daily living (ADL) assistance for 2 of 2 residents (R9, R38) who required staff assistance to make it out to meals. Refer to F804: the facility failed to ensure food was served at warm, palatable temperatures for 3 of 3 residents (R9, R64, R50). (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R38's progress notes dated 1/19/24 at 9:39 p.m., indicated R38 did not receive a shower due to staffing problems. During interview on 4/15/24 at 1:34 p.m., family member (FM)-I stated the facility was short on staff and did not think care was good because staff rushed in order to get on to the next person. During interview on 4/17/24 at 7:24 a.m., dietary aide (DA)-A stated breakfast started at 7:30 a.m., and serving went until 9:00 a.m. During interview on 4/17/24 at 10:29 a.m., DA-A stated R9 had to come out to the dining room to eat and was normally out by 9:30 a.m., and stated R9 did not receive breakfast because he did not come out to the dining room. During interview on 4/17/24 at 10:47 a.m., NA-C stated R9 did not receive any breakfast and R9 liked oatmeal and scrambled eggs however, they were really running behind, but stated she would ask R9 if he wanted toast. During interview on 4/17/24 at 12:58 p.m., NA-C stated when they started the shift, NA-C was working as a trained medication aide (TMA) and there was only two aides, NA-C began working as an NA after an agency nurse came in and R9 did not eat breakfast because they were behind and R9 did not eat meals in his room, nor did he take medications in his room. During interview on 4/18/24 at 8:21 a.m., NA-C stated R9 required assist with peri care, dressing, and stated they completed most of R9's activities of daily living (ADLs). During interview on 4/18/24 at 9:35 a.m., DA-A stated he was finished serving and did not know why R9 and R38 had not received a meal tray. During interview on 4/18/24 at 8:53 a.m., nursing assistant (NA)-N stated if there was a call in, they worked with only two aides and if you worked with an agency staff it was chaotic and difficult to get work completed. NA-N stated if there was a call in, one week the 4th floor would work short and the next week another floor would work short and so on. During interview on 4/18/24 at 9:35 a.m., dietary aide (DA)-A stated he was finished serving and did not know why R9 and R38 did not receive a meal. During interview on 4/18/24 at 9:41 a.m., NA-L stated they would benefit having a float staff to help with showers because there were new residents and times were getting scrambled and residents wanted to get up at the same time. NA-L further stated NA-M was a new staff person. NA-L further stated she wanted residents to eat by 9:00 a.m., because lunch came at 11:30 and would ask a resident if it was past 10:30 a.m., if they wanted a snack and tried to make sure they received lunch first. NA-L further stated at times, some residents were eating breakfast when lunch was being served. NA-L stated she did not know what the process was if there was a call in and further stated they had been short a week straight and further stated they had a call in this morning, but it wasn't on the 4th floor and they received text messages to get people to move around. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 4/18/24 at 9:54 a.m., NA-C stated NA-M's group had a lot of residents who required a mechanical lift and if you were not a regular staff person; it was difficult to get the residents up in a timely manner. NA-C further stated it was not ok to miss breakfast. During interview on 4/18/24 at 10:00 a.m., NA-C stated now that she was finished passing medications, she was going to offer her help. During interview on 4/18/24 at 10:03 a.m., NA-M stated she was going to finish R9 and further stated R38 did not refuse to get up; she had just not had the chance to go in to assist R38 yet. During interview on 4/18/24 at 11:23 a.m., the registered dietician (RD)-H stated R38 should have three meals a day and sometimes skipped breakfast per his choice depending on what time he got up. RD-H further stated if a resident wanted to get out of bed and was not getting help, it was not acceptable to miss breakfast. RD-H further stated their culinary staff relied on nursing staff to get residents out of bed and their staff had to wait until the resident was out in the dining room. During interview on 4/18/24 at 12:27 p.m., licensed practical nurse (LPN)-A stated she had 29 to 30 residents and there were 3 NA's on the 4th floor along with two nurses or one nurse and a trained medication aide (TMA) and LPN-A who was the clinical manager. Every day the director of nursing, administrator and the staffing coordinator met and if the staffing coordinator is on site would manage who was moving around. LPN-A stated they had a sick call in today and were able to move people quickly. During interview on 4/18/24 at 1:30 p.m., the director of nursing (DON) stated they looked at case mix and how many two person lifts and what the acuity was to determine staffing levels. DON further stated normal staffing was 3 nursing assistants and either a nurse and a TMA, or two nurses plus the clinical manager. DON stated they cut back on agency staffing and stated they had 2 to 4 aide positions open and for nurses maybe 6 positions opened. The DON stated they planned to add a 4th aide on the day and p.m. shift on the 4th and 5th floor. The DON further stated they were short in the morning due to a call in and got people to come in, however it was later in the morning and stated it was important residents receive their activities of daily living (ADLs) to maintain healthy nutrition and hydration and expected residents to get up for meals or if there was a working challenge to eat in their room. During interview on 4/18/24 at 2:29 p.m., the culinary director (CD) stated the facility provided three meals, breakfast, lunch, and dinner and a meal consisted of a protein, a starch, a dessert and a vegetable and toast was not considered a meal. 42580 R1 R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment, required substantial/maximal assistance with eating, and dependent on staff for toileting hygiene. R1 was always incontinent of bowel and bladder. R1 did not have any swallowing issues and the care area assessment triggered for nutritional status. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R1's care plan updated 3/27/24, indicated R1 had no natural teeth and had no dentures. Nursing staff were to bring tray to room and assist R1 with feeding. R1's nursing assistant care (NA) sheet undated included soft bit sized, consistent carbohydrate, thin liquids. Cut meat. Assist with meals and as needed when family is not available at supper, cut up food for resident to pick up and place tray on right side within reach. R1's physician order dated 1/2/24, indicated diet included soft and bite size texture, breads okay; consistent carbohydrate. thin liquid. R1 face sheet printed 4/18/24, indicated diagnosis generalized anxiety disorder, dependence on supplemental oxygen, and nutritional deficiency. During observation on 4/17/24 from 8:45 a.m., to 9:09 a.m., R1 was in bed asleep and in same position, lying on back, from previous observation at 7:51 a.m. During observation on 4/17/24 at 9:14 a.m., NA-K and licensed practical nurse (LPN)- E were observed completing R1's morning cares. After the completion of morning cares R1 was asked if had breakfast but could not recall if she had eaten breakfast. During interview on 4/17/24 at 10:09 a.m., NA-K stated they had filled out R1's diet slip and handed to dietary staff however had not seen R1's tray yet but had not gone to dietary to follow up on R1's breakfast tray. NA-K stated R1 required staff assist with meal set up and limited assist with feeding. NA-K verified R1 was assigned to her group but had not brought R1's breakfast to her and she had not had any breakfast at the time and R1 had not refused breakfast. During observation and interview on 4/17/24 at 2:00 p.m., R1 was lying in bed and when asked about breakfast stated, she was not sure if she had breakfast or lunch, but was hungry and asked surveyor to get her something to eat. Surveyor notified nurse manager LPN-B regarding R1's request. During interview on 4/17/24 at 2:06 p.m., nurse manager LPN-B stated was unsure if R1 had had breakfast or lunch but but would verify with NA-K. LPN-B stated thought R1 had refused breakfast at 7:30 a.m., when NA-K had asked but was unaware if R1 was reapproached after initial refusal or if she had had breakfast or lunch. A policy, Staffing and Daily Work Assignments, dated 2/2019, indicated sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. All nursing service personnel shall follow daily work assignments and perform assigned duties in accordance with professional standards of practice. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident cares services. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Changes in work assignments must be approved by the supervisor.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure food was served at warm, palatable temperatures for 3 of 3 residents (R9, R64, R50). Findings include: R9's quarterly Minimum Data Sets (MDS) dated [DATE], indicated R9 had intact cognition, did not have physical, verbal, or other behaviors, and did not reject cares, required set up or clean up assistance with eating, substantial to maximum assistance with showering/bathing, partial to moderate assistance with upper body dressing, personal hygiene, and was dependent on staff for lower body dressing, chair to bed and bed to chair transfers, and required substantial to maximum assistance with sitting to standing. R9's physician orders indicated the following order: 12/18/23, RG7 (normal everyday foods of various textures that are developmentally and age appropriate. Biting and chewing ability needed.) regular texture cardiac less than 2400 milligrams (MG) of sodium diet and thin liquids. R9's Face Sheet form dated 4/17/24, indicated R9 had morbid obesity due to excess calories, had chronic kidney disease stage 3, prediabetes, muscle weakness, anxiety, and depression. R9's care plan dated 4/16/24 indicated R9 had a potential for alteration in nutrition and was able to feed himself with meal set up and interventions included: small meal portions to support weight loss per resident wishes, staff to offer salads and saltine crackers with soups at lunch and dinner meals per resident preference. Likes egg, cheese, cucumber and tomato, likes apples, sandwiches, oatmeal, juice, coffee, celery, raspberry vinaigrette dressing, dislikes carrots, provide meal set up. Diet per physician orders, encourage adherence to therapeutic diet per physician orders, encourage good food and fluid intakes at and between meals as needed. R9's care sheet indicated R9 was on an RG7, 2200 milliliter (ML) fluid restriction, and preferred hot meals and ice in cold drinks. During interview on 4/15/24 at 6:01 p.m., R9 stated carrots were not cooked properly and stated they were difficult to chew when you don't have teeth. R64's significant change in status MDS dated [DATE], indicated severe cognitive impairment, did not have physical, verbal, or other behaviors, and did not reject cares, required partial to moderate assist with eating, oral hygiene, dressing, and transferring. R64's care plan dated 3/27/24, indicated R64 was on hospice and the facility was to provide daily cares. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R64's care plan dated 3/27/24, indicated R64 was potentially at risk for altered nutrition and was able to feed himself with some difficulties due to Parkinson's disease and interventions included: providing three meals a day and offer snacks. R64's care plan dated 4/16/24 indicated R64 had an alteration in skin integrity and interventions included providing a diet per physician's order. During interview on 4/15/24, at 1:35 p.m., R64's family member (FM)-I stated the food needed improvement and stated some nights the food was cold, not cooked enough, and sometimes the food was burned. R50's annual MDS dated [DATE], indicated intact cognition, did not have physical, verbal, or other behaviors, and did not reject cares and had weight loss of 5% or more in the last month or 10% or more in the last 6 months and was on a therapeutic diet. R50's care sheet indicated R50 required assist of two with a hooyer lift for transfers, was incontinent of bowel and bladder, preferred to get out of bed by 8:00 a.m. During interview on 4/17/24 at 7:24 a.m., dietary aide (DA)-A stated breakfast started at 7:30 a.m., and serving went until 9:00 a.m. During interview and observation on 4/17/24 between 9:32 a.m., and 9:46 a.m., the dietary aide checked food temperatures on the steam tables. The poached eggs were 110 degrees Fahrenheit (F), the Canadian bacon was also 110 degrees F, scrambled eggs were 130 degrees F, at 9:35 a.m., the eggs [NAME] sauce was 120 degrees, and the oatmeal was 125 degrees F at 9:36 a.m. DA-A stated eggs were supposed to be 160 degrees and meat was supposed to be 170 degrees when they came out of the oven. DA-A stated he did not know what the temperature was supposed to be on the steam tables, but stated the steam table was on the highest setting and was the best it could be. DA-A verified there were still residents who had not eaten including R9, R50, and R64. At 9:46 a.m., DA-A verified the steam table was on high and stated they had problems with the steam table on another floor however that was fixed and they had problems with the steam tables from time to time. During observation on 4/17/24 at 9:54 a.m., R9 was in his room and had not had breakfast. During interview on 4/17/24 at 9:59 a.m., the culinary director (CD) stated the holding temperature for foods on the steam table should be at 145 degrees and stated the temperatures DA-A obtained were low and stated they checked temperatures in the kitchen before food was brought up to the floors and had had a lot of turnover and temperatures were not consistently completed. CD further stated staff were probably running behind. CD further stated the dietary aides should know what the holding temps should be but it was still a training process and stated DA-A had been with the facility two years. CD further stated if resident's reported cold food, staff could contact the CD to resolve the concern. During interview on 4/17/24 at 10:29 a.m., DA-A stated R9 had to come out to the dining room to eat and was normally out by 9:30 a.m., and stated R9 did not receive breakfast because he did not come out to the dining room. During observation on 4/17/24 at 10:32 a.m., R9's door was closed. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/17/24 at 10:34 a.m., nursing assistant (NA)-C brought R9 out of his room and wheeled resident down towards the dining room. During interview on 4/17/24 at 10:47 a.m., NA-C stated R9 did not receive any breakfast because R9 liked oatmeal and scrambled eggs and they were running behind, but stated she would ask R9 if he wanted toast. During observation on 4/17/24 at 10:52 a.m., NA-C offered toast and R9 stated he did not eat bread and said he would wait until lunch. R9 did not get oatmeal and was not offered oatmeal. During interview on 4/17/24 at 12:58 p.m., NA-C stated R9 did not eat breakfast because they were behind. During interview on 4/17/24 at 1:19 p.m., R9 stated staff got him up about 10:30 a.m., and R9 had to wait until lunch to get something to eat. R9 stated that has happened 3 or 4 times and stated he was hungry and further stated he lived on oatmeal with brown sugar and scrambled eggs, but because it was too late, could not get it and when it waits too long, it is cold and then stated he did not want cold food. R9 stated he liked to be up around 9:00 a.m. During interview on 4/18/24 at 8:21 a.m., NA-C stated R9 required assist with peri care, dressing, and stated they completed most of R9's activities of daily living (ADLs). A policy, Maintaining Proper Food Temp During Food Service, dated August 2019, indicated food would be maintained at proper hot and cold temperatures prior to and during meal service to assure food quality and tastiness/palatability as well as food safety. The temperature of TCS (time/temperature control) hot food will be 135 degrees F or higher during tray assembly. Temperatures will be taken and recorded for all hot and cold items at all meals. Temperatures will be recorded. Heating food in the steam table is prohibited. Heating food to the proper temperature is accomplished by direct heat i.e. stove, oven, and steamer and food is then transferred to the preheated steam table not more than 30 minutes before meal service.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49654 Based on observation, interview and document review, the facility failed to label, date and store food in a sanitary manner to prevent food borne illness for food brought into the facility by a resident, family or guest. In addition, the facility failed to properly label, date and store meal trays held after meal service for 2 of 2 meal trays. This deficient practice had the potential to affect 3 of 3 residents residing on the fifth floor. Findings include: During observations on 4/15/24, at 12:40 p.m., a small glass containing orange liquid was sitting on R3's bedside table. Additionally, an open jar of salsa was observed sitting on the windowsill. At 4:43 p.m., R3 was observed in his room, and the glass that had contained the orange liquid was empty and R3 stated it was from his breakfast that morning and he drank it when he came back from an appointment at approximately 4:00 p.m. During subsequent observations between 4/15/24 at 2:03 p.m., and 4/17/24 at 07:43 a.m., the jar of open salsa remained on R3's windowsill. During tour of fifth floor kitchenette, and interview with culinary director on 4/16/24, at 2:38 p.m., two meal trays were observed on the counter just outside and to the right of the kitchenette door. Plates were covered and had visible condensation on the inside of the plate covering. Culinary director stated meals held after a meal service should be labeled with resident name, time, and date. Furthermore, any meals without that information would need to be thrown out as there is no way to identify exactly how long the meal had been sitting out. Additionally, food brought into facility from an outside source would need to be labeled and stored in the kitchenette. During interview with CNA-E on 4/16/24, at 03:38 p.m., CNA stated food coming in from the outside needed to be labeled right away to avoid a resident getting sick from food not being stored correctly. During interview with certified nursing assistant (CNA- F) on 4/16/24, at 03:43 p.m., CNA-F stated all food brought to resident from an outside source needed to be labeled and dated for each individual resident and perishable items stored in the kitchenette fridge. During interview with licensed practical nurse (LPN-N) unit manager on 4/17/24, at 07:43 a.m., LPN-B stated staff should label all food with resident's name and date and store in the kitchenette. In addition, open perishable food that is found in a resident's room undated should be immediately thrown away to avoid any potential food borne illnesses or contamination. During interview with administrator on 4/17/24, at 09:00 a.m., administrator stated when food is brought into the facility for a resident from any outside source, the item must be labeled and dated and stored in the kitchenette where it can be held for up to three days. Furthermore, she stated her expectation of staff would be to discuss the risks of food borne illnesses with the resident and establish a plan for safe food storage to avoid any potential food borne illnesses caused by food not properly being stored. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Safe food storage and handling for food brought in by residents, families and visitors indicated all food brought into the facility should be labeled with the date the product was brought into the facility, the use by date (max of 3 days), name and room number of resident.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed for 2 of 2 residents (R42, R1) and failed to ensure proper personal protective equipment (PPE) for 2 of 2 residents (R18, R1) observed for contact precautions and enhanced barrier precautions and failed to ensure proper cleaning of a mechanical lift following use was completed for 1 of 1 resident (R42) Findings include: R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment, did not have behaviors and did not reject care, required substantial assistance with toileting and hygiene, partial to moderate assist with bathing, dressing, substantial assist for standing and transferring, was not on a toileting program, and was frequently incontinent of bowel and bladder. R18's Face Sheet form dated 4/15/24, indicated the following diagnoses: viral intestinal infection, repeated falls, gastro esophageal reflux disease with esophagitis without bleeding. A form provided by the facility indicated resident names, any medical devices or wounds and under the heading Notes indicated R18 had suspected norovirus. R18's physician orders indicated the following orders: 4/14/24, collect stool sample for fecal testing (Norovirus) special instructions: discontinue order after results obtained and called to the provider. 4/15/24, contact enteric precautions due to signs and symptoms of Norovirus. 4/15/24, strict contact enteric precautions due to signs and symptoms of Norovirus, isolate to room. R18's nursing progress notes dated 4/15/24, indicated a stool sample was sent due to symptoms of vomiting and loose stools times. Further, the note indicated, This writer put resident on enhanced barrier protections until test results are returned. R18's care plan dated 4/15/24, indicated R18 was on contact isolation precautions due to signs and symptoms of norovirus and interventions indicated an isolation care would be placed outside resident's room, R18 would remain in the room at all times, staff would perform proper handwashing, PPE placement and removal per facility policy prior to entering and when exiting room, staff will wear appropriate PPE related to R18's precautions. R18's care plan dated 3/20/24, indicated R18 had a urinary tract infection was was on an antibiotic. R18's care plan dated 8/28/23, indicated R18 was incontinent and required a bedpan and bedside commode. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview and observation on 4/15/24 at 6:52 p.m., R18 was in her room in bed and a sign was located on the door for contact enteric precautions. The signage indicated everyone must clean hands with sanitizer when entering room and wash with soap and water upon leaving the room. Doctors and staff must gown and glove at the door and use patient dedicated or disposable equipment and clean and disinfect shared equipment. R18 had finished eating her meal in her room and asked if her bedside table could be moved closer to the bed. R18 activated her call light at 7:01 p.m. and at 7:02 p.m., nursing assistant (NA)-D entered R18's room without gloves or a gown. NA-D grabbed R18's meal tray and brought it into the bathroom then moved the bedside table to the resident's bedside without gloves or gown on and then picked up R18's meal tray and left the room. NA-D stated she did not wear a gown or gloves because NA-D did not provide personal cares on R18. During interview on 4/15/24 at 7:04 p.m., registered nurse (RN)-E stated R18 was on contact precautions due to suspected Norovirus and expected staff to wear PPE at all times and wash their hands when leaving the room. During interview on 4/17/24 at 9:03 a.m., licensed practical nurse (LPN)-A stated R18 was on enteric precautions and expected staff to don PPE before going into the room and disposing of PPE when leaving and stated PPE included a mask, gown, and gloves. LPN-A further stated it was important to don PPE because Norovirus can be on surfaces NA-D touched and could be carried to other residents. During interview on 4/18/24 at 11:51 a.m., the infection preventionist, (IP) and the director of nursing stated they expected staff to perform hand hygiene and don gloves, gown to enter the room and when going to touch anything in the room. R42's admission assessment dated [DATE], indicated R42 was incontinent of bowel and bladder, required assist of 2 staff with toileting, bed mobility and repositioning. Additionally, R42 required continuous oxygen via nasal cannula. During observation on 4/15/24, at 01:13 p.m., signage posted outside of R42's door, and directly above a three-drawer plastic cart containing personal protection equipment, indicated need for standard precautions (a basic level of infection control that should be used in the care of all patients all of the time). Review of R42's medical record indicated this was required for staff providing cares related to R42's gastrostomy tube (G-tube: a tube inserted through the belly that brings nutrition or medications directly to the patient's stomach). During observation of cares for R42 on 4/15/24, at 02:09 p.m., certified nursing assistant (CNA)-H, with the assistance CNA-B, provided peri care to R42 after using the bedpan. R42 was transferred to bed using a mechanical lift. While wearing gloves CNA-H used a wet washcloth to clean the resident's peri area. CNA-H did not remove soiled gloves, or complete hand hygiene after providing peri care and immediately grabbed R42's oxygen nasal cannula, and assisted R42 to put it on her face. CNA-B removed her soiled gloves, did not complete hand hygiene, and took the mechanical lift out of R42's room without wiping down the mechanical lift. During interview on 4/15/24 at 02:28 p.m., CNA-B stated all mechanical lifts are supposed to be wiped down in between residents. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/15/24, at 0:600 p.m., CNA-G stated mechanical lifts should technically be cleaned before leaving a resident's room. Additionally, CNA-G reported she wasn't sure what wipes were to be used to clean the lift, then removed a white container with a blue top from the bag attached to the mechanical lift and indicated this was what is used to clean the lift. The label on the container read PDI sani hands. During interview on 4/15/24, at 07:18 p.m., with licensed practical nurse (LPN)-B unit manager, LPN-B stated staff should clean mechanical lifts before exiting a resident's room using either bleach or hydrogen peroxide wipes, and staff should never remove a lift from a room without first wiping it down. LPN-B stated this practice will reduce the risk of cross contamination between residents. Furthermore, hand hygiene should be completed after all contact encounters with residents, after removing soiled gloves, and any time hands are visibly dirty. 42580 R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment, was dependent for toileting hygiene. R1 was always incontinent of bowel and bladder. R1 care area assessment triggered for pressure ulcer. R1's care plan updated 3/26/24, indicated at risk for infection on Enhanced Barrier Precaution (EBP)related to extended-spectrum beta-lactamases (ESBL-enzymes that conferred resistance to most beta-lactam antibiotics, including penicillins, cephalosporins, and the monobactam aztreonam. Infections with ESBL-producing organisms have been associated with poor outcomes) and methicillin-resistant staphylococcus aureus (MRSA- infection caused by a type of staph bacteria that's become resistant to many of the antibiotics) in urine and R1 had active wounds. Care plan interventions included monitor signs and symptoms of infections. Access for EBP need and implement precautions according to facility protocol. R1's nursing assistant care sheet undated included EBP, incontinent, calmoseptine only. Check and change every 2-3 hours. R1's physician order dated 4/12/24, indicated calmoseptine ointment 0.44-20.6% topical for non-pressure chronic ulcer of buttock. R1 face sheet printed 4/18/24, indicated diagnosis generalized anxiety disorder, dependence on supplemental oxygen, hypertensive chronic kidney disease, and chronic pain syndrome. During observation on 4/17/24 at 9:12 a.m., R1 had EBP signage near door with personal protective equipment (PPE) supplies near door. Nursing assistant (NA-K) and licensed practical nurse (LPN)-E donned gown, mask and gloves and entered R1's room to complete morning cares. NA-K filled a bath basin with water and placed on R1's bedside table with other supplies. During pericare, NA-K cleaned R1's frontal area in a down to up motion from dirtiest to cleanliest. NA-K used a washcloth to dry R1's frontal area from down to up as well. R1 was turned to right side and NA-K used same glove to perform perineal care with and cleaned buttocks area, also using the same washcloth to clean skin area where R1 had an opened non-pressure related opened wound. NA-K then used the same glove after perineal care took R1's calmoseptine ointment 0.44-20.6% topical, and applied to non-pressure wound and surrounding skin. NA-K then changed gloves and donned new gloves to completed R1's morning cares. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Cerenity Marian of St Paul LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During continuous observation on 4/18/24 10:05 a.m., to 10:25 a.m., NA-K and NA-O entered R1's room and did not don gown, or gloves, with personal protective supplies stationed outside of R1's door. When surveyor knocked on R1's door and opened door NA-K and NA-O were observed without gown, completing morning cares for R1 and were repositioning R1 in bed. During interview on 4/18/24 at 10:31 a.m., NA-O stated they had completed morning cares for R1 including perineal cares and stated staff only needed to wear gloves even though they had direct contact with R1's non-pressure wound to buttocks. NA-K also stated was confused about when gowns should be worn for R1 and did not think gowns were needed in addition to glove use when providing perineal care fro R1 although had exposure to R1's buttock wound during perineal cares. During interview on 4/18/24 at 11:02 a.m., director of nursing (DON) stated it was the facility policy and an expectation that staff would wear gown, and gloves when performing a high contact activity such as providing morning cares with perineal cares for a resident with a non-pressure wound to buttock for EBP implementation. A policy, Contact Precautions, dated June 2017, indicated contact precautions were used when diseases were transmitted by contact with the resident or the resident's environment. Residents with disease caused by organisms that have been demonstrated to cause heavy environmental contamination will be placed on contact precautions. Diseases transmitted through contact transmission include, but are not limited to: acute infection with Methicillin Resistant Staphylococcus Aureus (MRSA), or Vancomycin Resistant Enterococcus (VRE), Clostridium difficile associated diarrhea, diarrhea and fecal incontinence or other organisms as determined by the facility's infection preventionist and medical director. Associates will change protective attire and perform hand hygiene between contacts with residents in the same room, regardless of whether one or both are on contact precautions. Hand hygiene is done prior to donning PPE, PPE is donned prior to entering room. A gown and gloves are needed upon entering room. Change gown and gloves between residents even if only one resident is on contact precautions. Use of masks, eye protection and face shields is not routinely a part of contact precautions, however, just as with standard precautions, these items are worn during resident care activities that are likely to create splashes or sprays of blood, body fluid, secretions, and excretions. Hand hygiene is performed between glove changes and when removing gloves.		