STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. Building B. Wing	02/06/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and document review the facility failed to ensure medications were administered per physicians' orders for 2 of 2 (R6, R150) residents reviewed for medication errors. This resulted in significant medication errors and actual harm when R6 received the wrong medications resulting emergent care and hospitalization for hypotension (low blood pressure), lethargy, and possible aspiration. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], indicate R6 had severe cognitive impairment and diagnoses of dementia, depression and high blood pressure. Furthermore, R6's MDS indicated R6 did not take narcotic medications. R6's Safety Events- Medication Error report dated 2/2/25, indicated R6 received R229's medications. The medications R6 received in error included the following: -Methadone (narcotic pain medication) 2.5 milligrams (mg) -gabapentin (medication to treat nerve pain) 900mg -omeprazole (medication to prevent acid reflux) 20mg -senna (medication to prevent constipation) 2 tablets -tamsulosin (medication to treat enlarged prostrate) 0.4mg -MiraLAX 17grams (medication to prevent constipation) The report further indicated R6's blood pressure had decreased from >100 systolic to 55 systolic over the course of 2 hours. Staff gave Narcan (medication to reverse the effects of narcotic medication) and R6 transferred to a higher level of care. Furthermore, R6 required additional observation overnight in the hospital. R6's provider orders lacked indication R6 had been prescribed Methadone, gabapentin, omeprazole, senna, tamsulosin or MiraLAX. (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R6's nursing progress note dated 2/2/25 at 9:28 a.m., indicated R6 had been given R229's morning medications. The error was noted at 9:00 a.m., and R6's vital signs were blood pressure (BP) 105/57, pulse 65, 97% oxygen saturation on room air. The on-call provider was notified and instructed vital signs to be taken every hour for 12 hours, then every 4 hours for 24 hours. If R6 became sedated, staff should administer Narcan and send to the hospital. R6's nursing progress note dated 2/2/25, at 1:39 p.m., indicated the provider was notified R6's blood pressure was low. R6's nursing progress note dated 2/2/25 at 2:39 p.m., indicated R6 had been transferred to the hospital. R6's vital signs dated 2/2/25 indicated the following: -at 11:06 a.m., BP was 107/67 and pulse 61 -at 12:34 p.m., BP was 98/62 and pulse 52 -at 1:35 p.m., BP was 55/35 and pulse 56 R6's Hospital Medicine History and Physical dated 2/2/25, at 8:14 p.m., indicated R6 was admitted for accidental ingestion and refractory hypotension. In the emergency department, R6 had ongoing sedation and hypotension. R6's mental status improved to near baseline however the hypotension continued. R6 had normal respirations and did not require supplemental oxygen. There was some concern for aspiration and R6 was started on an antibiotic however there was low suspicion for an infection onset prior to the accidental ingestion as it was reported R6 was in usual state of health before medication administration. R6 was admitted for close monitoring and management of blood pressures. R229's admission MDS dated [DATE], indicated R229 was cognately intact and had a diagnosis of bone cancer. R229 received hospice services. When interviewed on 2/4/25 at 9:04 a.m., family member (FM)-A stated R6 was given the wrong medication on 2/2/25. FM-A stated there was a newer nurse and R6 was given R229's morning medications as both had the same first name. FM-A stated they had been in contact with the hospital and due to the Methadone and gabapentin, R6's blood pressure was low and needed intravenous fluids and monitoring. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	When interviewed on 2/5/25 at 10:27 a.m., trained medication assistant (TMA)-A stated they were working with licensed practical nurse (LPN)-A on 2/2/25 when the medication error happened. TMA-A stated during medication pass, LPN-A asked if there were any of his residents in the dining room. TMA-A stated R6 was seated in the dining room for breakfast and told LPN-A. R6 from room [ROOM NUMBER] was. TMA-A stated LPN-A went over to where R6 was seated and administered medication. A short while later, LPN-A then asked where R6 was. TMA-A stated R6's medications were given as R6 was seated in the dining room. TMA-A asked LPN-A if R229's medications were given to R6 as they have the same first name. It was then LPN-A had realized he administered R229's medications to R6. TMA-A stated LPN-A had notified the provider and monitored R6 for any changes. TMA-A stated R6 appeared to have a normal morning and had normal behaviors during breakfast. At one point, TMA-A stated R6 wanted to lay down and did before lunch. TMA-A stated when R6 came out for lunch, R6 was falling asleep during lunch at the dining room table. TMA-A stated this was unusual for R6. R6 appeared weak and very tired so he was laid back in bed. That was when R6's blood pressure was 50's over 30's. LPN-A had notified the provider again and gave Narcan. R6 was then sent into the emergency room . TMA-A stated R6 appeared to have a normal morning before the wrong medications were given and after, appeared to be tired and lethargic. When interviewed on 2/5/25 at 10:42 a.m., registered nurse (RN)-A stated nurses should be making rounds and introducing themselves when they were new to the unit. RN-A further stated residents could be identified with their pictures, names on their rooms and by other staff who worked the units regularly. RN-A acknowledged LPN-A gave R229's medications to R6 in error and further stated there were two residents with the same name. LPN-A had worked on other units in the building however it was the first time working on this floor. RN-A expected nursing staff to use the seven rights for medication administration and verify the correct resident received the right medications. When interviewed on 2/5/25 at 1:30 p.m., nurse practitioner (NP)-A was aware R6 had been given R229's medications in error. NP-A further stated the medication error absolutely contributed to R6's low blood pressure and was the reason R6 required additional monitoring in the hospital. When interviewed on 2/5/25 at 2:35 p.m., clinical pharmacist (CP) was aware of R6's medication error. CP stated R6 had received R229's methadone and gabapentin which had the greatest potential for a negative outcome. CP explained the methadone dose was low; however, gabapentin can potentiate the methadone making it have greater effects. CP stated this was a significant medication error that resulted in R6 needing hospitalization . When interviewed on 2/6/25 at 8:49 a.m., the administrator acknowledged R6's medication error and need for hospitalization . The administrator further stated the unit had two residents with the same first name and LPN-A did not clarify the correct name when giving morning medications. The administrator had been leading the facility investigation into the error. The administrator stated education was ongoing for all nurses and TMAs before the start of their shift about resident identification. Furthermore, pictures of all residents have been reviewed to ensure they were up to date and clear. When interviewed on 2/6/25 at 11:49 a.m., the Director of Nursing (DON) expected all staff to utilize the 7 rights of medication administration. DON further stated there were names on the doors, pictures on file, or staff who were nor familiar with the unit were expected to verify with other staff who normally worked on the unit. 22580 (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R150's initial Minimum Data Set (MDS) dated [DATE], indicate R150 had severe cognitive impairment. R150's face sheet indicated R150 had diagnoses of humerus fracture, type 2 diabetes mellitus, chronic kidney disease, and hearing loss. R150's Safety Events- Medication Error report dated 2/3/25, indicated R150 received R149's medications. The medications R150 received in error included the following: -amlodipine (medication totreat high blood pressure) -citalopram (medication to treat depression) -furosemide (medication to treat fluid retention) -gabapentin (medication to treat seizures and peripheral neuropathy) -metformin (medication to treat type 2 diabetes) R150's provider orders lacked indication R150 had been prescribed amlodipine, citalopram, furosemide, gabapentin, or metformin. R150's nursing progress note dated 2/3/25 at 10:10 a.m., indicated R150 had received wrong medication given by nurse from other unit. R150's vital signs were blood pressure (BP) 109/65, heart rate 92bpm (beats per minute), respirations 17, O2sat (oxygen saturation) 97% and temperature 97.5 F. The on-call provider was notified and instructed to hold the PRN Oxycodone (as needed pain medication) for 24 hours, and to check vital signs every hour and monitored for any adverse reaction accordingly. R150's nursing progress note dated 2/3/25, at 1:13 p.m., indicated the resident was observed slashing around in bed with her bed at the end of the bed and feet at the pillow(sic). Resident was yelling out and son is present. He was unable to get her to tell him what was wrong and bothering her. Son sat with resident and writer called NP Nurse practioner) to give update. NP gave order to send resident to the ED (emergency department) for cardiac monitoring due to resident receiving another residents medication this morning. R150's nursing progress note dated 2/3/25 at 5:40 p.m., indicated R150 returned to facility by hospital transport at this time. R150's Hospital After visit summary dated 2/3/25, at 6:16 p.m., indicated R150 was at the emergency room from 1428 (2:28 p.m.) until discharge at 1700 (5:00 p.m.). In the emergency department, the hospital looked at the doses of medications you accidentally took, and spoke to poison control. No additional monitoring needs to be performed. When interviewed via telephone on 2/5/25 at 11:36 a.m., Licensed Practical Nurse (LPN)-A stated she was working on 2/3/25 on the 3000 floor. They indicated it was their first shift at the facility. They came in early for training, and started doing medication administration by going room to room. They indicated R150 and R149's room were next to each other. They indicated they dished up 149's medication, and were distracted, and went into R150's room and administered R149's medications. They went to the medication cart and immediately realized they had given the wrong resident the wrong medication and immediately reported it to the Registered Nurse (RN) on the floor (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	When interviewed on 2/5/25 at 9:20 p.m.,NP-A was aware R150 had been given R149's medications in error. NP-A further stated she was here when the medication error occurred, as was R149's doctor. NP-A indicated they discussed the medications R150 had received and were concerned that the gabapentin might interact with the other medications. NP-A indicated they were notified later in the afternoon that the resident was restless and to send them to the emergency room . When interviewed on 2/5/25 at 2:35 p.m., clinical pharmacist (CP) was aware of R150's medication error. CP stated R150 had received R149 's metformin and might cause R150 stomach issues. CP indicated the medication was nothing really dangerous, and the emergency department sent her back without further orders When interviewed on 2/6/25 at 8:57 a.m., the administrator acknowledged R150's medication error and need for emergency room visit. The administrator further stated she had not yet spoke to LPN-B, but would get her statement. The administrator had been leading the facility investigation into the error as it was the second one in two days. The administrator stated education was ongoing for all nurses and TMAs before the start of their shift about resident identification, and following the seven rights of medication administration. When interviewed on 2/6/25 at 11:49 a.m., the Director of Nursing (DON) expected all staff to utilize the 7 rights of medication administration. DON further stated there were names on the doors, pictures on file, or staff who were nor familiar with the unit were expected to verify with other staff who normally worked on the unit. A facility policy titled Medication Administration revised 8/31/23, directed staff to administer medications by ensuring the right resident, right medication, right dose, right time, right route, and right documentation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and record review the facility failed to ensure dishwasher temperatures were within range to ensure resident dishes were sanitized for 3 of 3 kitchenettes located on resident units. Furthermore, the facility failed to ensure expired milk was removed from 1 of 3 kitchenettes (3rd floor) and clean resident dishes were stored to prevent contamination from dust/debris for 1 of 3 kitchenettes located on resident units (4th floor). This had the potential to impact all residents who reside in the facility. Findings include: A facility document titled 3rd and 4th floor Dish Machine from Ecolab dated 2024, indicated the operating temperatures were a minimum wash temperature of 155 degrees Fahrenheit (F) and a minimum rinse temperature of 180 degrees F. A facility document titled 5th floor Dish Machine from Ecolab dated 2018, indicated the operating temperatures were a minimum wash temperature of 150 degrees F and a minimum rinse temperature of 180 degrees F. 4th floor Kitchenette A facility document titled Dish Machine Temperature Log 4th floor dated ,d+[DATE], indicated 5 of 5 days had final rinse temperatures at 180 degrees F or above, however, 0 of 5 days had wash temperatures documented at 155 degrees F or above. A facility document titled Dish Machine Temperature Log dated ,d+[DATE], indicated 17 of the 31 days had final rinse temperatures of 180 degrees F or above. The log further indicated 0 of the 31 days, had wash temperatures were documented at 155 degrees F or above. On [DATE] at 2:01 p.m., the 4th floor kitchenette was reviewed. An Ecolab dishwasher was used to cleaning resident plates from lunch. Dishwasher temperatures were observed to be 109 degrees for a wash cycle and 185 degrees for the rinse cycle. Culinary aide (CA)-A unloaded clean plates from the dishwasher and stacked them onto a plate storage container. The plates were not covered. Above the clean plates was an air grate that was visibly dirty with gray dust and dirt. There were strands of dust hanging down from the grate. When interviewed on [DATE] at 2:10 p.m., CA-A stated the dishwasher used chemicals to sanitize resident dishes. CA-A further stated dishwasher temperatures were monitored at mealtimes and documented on a temperature log, but litmus strips to ensure the appropriate chemical sanitizing was not completed on the resident units. CA-A verified the dust/debris in the grate above the clean dishes and was not sure how often or who was responsible to clean them. When interviewed on [DATE] at 2:16 p.m., maintenance (M)-A verified the dust and debris in the grate. M-A was not sure who cleaned those vents and would check with their supervisor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5th floor Kitchenette A facility document titled Dish Machine Temperature Log 5th floor dated ,d+[DATE], indicated the 1 of 5 days had final rinse temperatures of 180 degrees F or above. The log further indicated 2 of the 5 days had wash temperatures documented at 150 degrees F or above. A facility document titled Dish Machine Temperature Log 5th floor dated ,d+[DATE], indicated 13 of the 31 days had final rinse temperatures of 180 degrees F or above. The log further indicated 6 of the 31 days, had wash temperatures were documented at 150 degrees F or above. On [DATE] at 8:14 a.m., the 5th floor kitchenette was reviewed. An ecolab dishwasher was in use washing resident dishes. The wash temperature was 159 degrees, and the rinse temperature was 182 degrees. When interviewed on [DATE] at 8:18 a.m., CA-B stated the dishwasher was a high temperature dishwasher and temperatures were monitored and documented on the temperature log. CA-B stated twice a day temperatures were monitored usually at lunch and dinner. CA-B verified the last temperatures documented were 124 degrees for washing and 165 for rinse on [DATE] at 6:16 p.m. 3rd floor kitchenette A facility document titled Dish Machine Temperature Log 3rd floor dated ,d+[DATE], indicated the 0 of 5 days had final rinse temperatures of 180 degrees F or above. The log further indicated 0 of the 5 days had wash temperatures documented at 150 degrees F or above. A facility document titled Dish Machine Temperature Log 3rd floor dated ,d+[DATE], indicated 6 of the 31 days had final rinse temperatures of 180 degrees F or above. The log further indicated 6 of the 31 days, had wash temperatures were documented at 150 degrees F or above. On [DATE] at 8:23 a.m., the 3rd floor kitchenette was observed. In the refrigerator were 5 individual containers of prairie farms 1% chocolate milk with best by dates of [DATE]. Next to the chocolate milk were stacks of individual Glenview Farms skim milk. Two of the skim milk containers had no best by dates on them. The rest of the skim milk containers had a best by date of [DATE]. An Ecolab dishwasher was started, and a wash temp was 155 degrees and a rinse temp was 165 degrees. When interviewed on [DATE] at 8:52 a.m., CA-C verified the chocolate milk's best by date was 2 days ago and stated they should not be in here. CA-C removed them and threw them away. CA-C further stated sometimes the milk does not have a best by date stamped on but all of the milks come out of the same box. If a milk didn't have a date and the other milks around it had a date, it was ok to go by that one as they would all be the same. CA-C verified the dishwasher rinse temperature did not reach 180 degrees and further stated it usually did. CA-C stated if the temperatures were not high enough, the dishes would be washed a second time. CA-C then started the dishwasher again. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on [DATE] at 11:15 p.m., the culinary director (CD) stated the dishwashers on the resident floors used chemicals to sanitize dishes. CD verified litmus strips were not used on the floor to ensure the effectiveness of chemicals and only the temperatures were monitored. CD wasn't sure what the temperatures should be and would follow up. CD stated the CA's stocked the unit kitchenettes daily and expected any outdated items to be removed and expected staff to have removed the chocolate milk. CD was not aware of missing best by dates on the individual cartons of milk however expected a process to ensure the dates were known. CD stated there had been issues with dirty vents on the 4th floor and stated when dirty vents were noticed, maintenance should be notified so they can be cleaned. When interviewed on [DATE] at 12:48 p.m., the Administrator stated the CD would know what kind of dishwashers were used on the resident units and expected the guidelines to be followed to ensure resident dishes were clean and sanitized. Furthermore, the Administrator expected any dust or dirty vents/grates to be cleaned and items removed from stock that were outdated. A follow up interview on [DATE] at 2:32 p.m., the CD verified the dishwashers on the units were all high temperature sanitizing and did not use chemicals to sanitize. CD verified the temperature logs did not always indicate the dishwashers were getting to the correct temperatures and expected staff to notify her so follow up with Ecolab could be completed. A facility policy titled Dishwashing Procedures no date, directed staff to operate in accordance to the manufactures instructions and the final sanitizing rinse will be 180 degrees F. A facility policy titled Food Storage- Perishable revised 2019, did not direct staff on a process for review of best by dates on items stored in the refrigerators.