Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 24, 2026

Administrator
CERENITY MARIAN OF ST PAUL LLC
200 EARL STREET
SAINT PAUL, MN 55106

RE: CCN: 245365
Cycle Start Date: March 18, 2026

Dear Administrator:

On April 21, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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April 24, 2026

Administrator
CERENITY MARIAN OF ST PAUL LLC
200 EARL STREET
SAINT PAUL, MN 55106

Re: Reinspection Results
Event ID: 1E3ED2-H2

Dear Administrator:

On April 21, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 18, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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March 30, 2026

Administrator
CERENITY MARIAN OF ST PAUL LLC
200 EARL STREET
SAINT PAUL, MN 55106

RE: CCN:245365

Cycle Start Date: March 18, 2026

Dear Administrator:

On March 18, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 18, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 18, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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March 30, 2026

Administrator
CERENITY MARIAN OF ST PAUL LLC
200 EARL STREET
SAINT PAUL, MN 55106

Re: State Nursing Home Licensing Orders
Event ID: 1E3ED2-H1

Dear Administrator:

The above facility survey was completed on March 18, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245365**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/18/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY MARIAN OF ST PAUL LLC	**200 EARL STREET , SAINT PAUL, Minnesota, 55106**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 3/16/26 through 3/18/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/20/2026
F0000	INITIAL COMMENTS On 3/16/26 through 3/18/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53658001C (2796459), H536558580C (2655845) and H53656581C (1139955), and H53655003C (2730410). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained	F0000		04/20/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F0689	On 3/16/2026 the space heater was immediately removed from resident #56's room. On 3/16/2026 all resident rooms were audited to ensure that no other space heaters were in-use in unauthorized areas. Immediate education began on 3/16/2026 for all staff	04/20/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245365	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY MARIAN OF ST PAUL LLC	200 EARL STREET , SAINT PAUL, Minnesota, 55106

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F0689 SS = D	Continued from page 1 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure the environment was free of potential hazards for 1 of 1 resident (R56) found to have a space heater operating in their room. Findings include: R56's quarterly Minimum Data Set (MDS) dated 2/5/26, identified moderately impaired cognition and no behaviors. R56 was independent with transfers and ambulation. Diagnoses included cardiopulmonary disease (heart and lung disease), diabetes and cataracts, glaucoma or macular degeneration (eye conditions that cause loss of vision). R56's Mood State care plan dated 3/12/26, identified she had a sleep pattern disturbance related to insomnia and to evaluate her room for noise, darkness, temperature and comfort. During an observation and interview on 3/16/26 at 7:42 a.m., R56 stated her room was too cool and she used a space heater provided to her from nursing. On the laminate style floor was a Holmes brand with model number HFH610 space heater set at 84 degrees on the digital reading. The space heater was blowing warm air and when tipped over did not automatically shut off. R56 stated she usually used the heater only at night. R56 denied being injured by the heater and was unsure how long it had been in her room. During an interview on 3/16/26 at 7:49 a.m., nursing assistant (NA)-A stated residents were not able to have space heaters in their room and was not aware of any in use. During an interview 3/16/26t a 7:51 a.m., registered nurse (RN)-B stated it was okay to give a resident a space heater if they complained of their room being cold. RN-A stated there was a space heater at the nurse's station and was not aware of any space heaters in use currently in resident rooms. During an interview on 3/16/26 at 7:51 a.m., the	F0689	Continued from page 1 regarding the prohibitive use of space heaters in resident rooms. Education continued until all staff were re-educated. An audit was completed of space heaters in the building. The existing space heaters were disposed of; we no longer have any space heaters. All purchases are reviewed and approved by the Executive Director; she will monitor for any purchases of space heaters and other prohibited hazards 3 rooms/floor/week will audited to ensure that no prohibited hazards are in the rooms. 2 rooms/floor/week will be audited for the next month. Finally, 1 room/floor/week will be audited for the final month. Issues identified related to space heaters will be referred to the facility's QAPI Team for input/suggestion. The Executive Director is responsible for ensuring that space heaters are not used in resident room/areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245365	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER: CERENITY MARIAN OF ST PAUL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 EARL STREET , SAINT PAUL, Minnesota, 55106	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 2 director of nursing (DON) also stated residents could not have space heaters in their rooms and entered R56's room and removed the space heater. During an interview on 3/17/26 at 11:20 a.m., the administrator stated they do not allow space heaters in resident rooms for safety reasons. The administrator stated the facility did not have a policy because space heaters were not allowed. The undated Product Safety Commission website identified Holmes HFH brand heaters had not been recalled. The Holmes HFH610 instruction manual was not able to be located. The Holmes Official Website - Premium Heaters dated 2026, identified Holmes heaters came with safety features like overheat protection and auto shutoff, and it was always recommended to follow the instruction manual and never leave any heater unattended for long periods while sleeping.	F0689		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: During observation, interview, and document review the facility failed to ensure supplemental oxygen was properly maintained for 1 of 1 resident (R40) reviewed for oxygen. Findings include: R40's quarterly Minimum Data Set (MDS) dated 3/6/26, indicated intact cognition and diagnoses of chronic respiratory failure with hypoxia (low oxygenation) and was dependent on supplemental oxygen. R40's physician's orders indicated the following: -on 5/22/25, R40 required continuous oxygen-wean as able per nasal cannula to keep oxygen saturation	F0695	Resident #40's humidifier jar was changed on 3/17/2026; the O2 tubing was changed as well. A list of residents receiving oxygen therapy was created; their humidifier jar and O2 tubing are changed per policy. The policy related to respiratory therapy was reviewed. The facility has changed their system for monthly humidifier jar changes and weekly O2 tubing. All humidifiers were changed out on 4/9/2026; going forward, all humidifier jars will be change on the first of the month. Additionally, the facility will change out all tubing on the same day/week. Education was provided to the licensed nurses on our policy and expectation for changing humidifier jars and O2 tubing. Resident's utilizing a humidifier jar will be audited monthly to ensure they are changed per policy. O2 tubing will be audited weekly to ensure that they are changed per policy. The audits will be done each month for 3 months to ensure compliance. Issues identified with respiratory care will be forwarded to the facility's QAPI team for input/suggestion. The Director of Nursing is responsible for ensuring that the humidifier jars and O2 tubing are changed per policy.	04/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245365	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY MARIAN OF ST PAUL LLC	**200 EARL STREET , SAINT PAUL, Minnesota, 55106**

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F0695 SS = D	Continued from page 3 greater than or equal to 90%. Oxygen at 1 LPM every shift. -on 10/1/25, order directed staff to change and date an oxygen humidifying jar monthly. R40's treatment administration record (TAR) dated 3/2026, indicated R40's humidifying jar was last changed on 3/1/26 and oxygen tubing was changed on 3/12/26. R40's Care plan dated 1/28/25, indicated R40 had ineffective breathing patterns related to chronic respiratory failure with hypoxia, dysphagia (problems swallowing) with aspiration risk. Interventions included: -Administer oxygen per doctor's orders, 1 liter per minute (LPM) via nasal cannula. -Check humidifying jar daily to see if needs fluid. Change humidifying jar and oxygen tubing weekly. -Encourage compliance with oxygen. Check oxygen sats and liter flow every shift as needed/per medical doctor's order. -Monitor portable oxygen concentrators/tanks every shift to make sure tank is not empty. Fill portable tanks per facility policy. -Oxygen as ordered; Measure & document oxygen saturation rates as needed. -Resident likes to take off oxygen on her own. Staff to continue to encourage oxygen use. During observation on 3/16/2026 at 9:09 a.m., R40's oxygen tank (in her room) had a humidifying jar with water in it and was dated 2/1/26. The oxygen tubing had an illegible label that read either 2/8 or 3/8. During observation on 3/17/26 at 11:24 a.m., R40 was in her room with oxygen on. The oxygen tubing in place had an illegible label that read either 2/8 or 3/8. The oxygen tank had a humidifying jar with water in it and was dated 2/1/26. During observation and interview on 3/17/26 at 11:27 a.m., registered nurse (RN)-A confirmed the humidifying jar was dated 2/1/26 and the tubing label was illegible and read either 2/8 or 3/8. RN-A stated the tubing should be changed weekly, and the humidifying jar should be changed monthly. During interview on 3/18/26 at 11:55 a.m., RN-B stated	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245365**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/18/2026**
NAME OF PROVIDER OR SUPPLIER **CERENITY MARIAN OF ST PAUL LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **200 EARL STREET , SAINT PAUL, Minnesota, 55106**		

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F0695 SS = D	Continued from page 4 nurses were responsible for changing the oxygen tubing and humidifying jars and the frequency depended on the doctor's orders for each specific resident. During interview on 3/18/26 at 12:00 p.m., RN-C stated nurses were responsible for changing the oxygen tubing and humidifying jars. The oxygen tubing should be changed weekly, and the humidifying jar should be changed monthly. This was determined by the facility's standing orders. During interview on 3/18/26 at 12:05 p.m., licensed practical nurse (LPN)-A stated nurses were responsible for changing the oxygen tubing and humidifying jars and there were standing orders for the tubing to be changed weekly and the humidifying jars to be changed monthly. LPN-A confirmed R40's TAR showed the humidifying jar was last documented as changed on3/1/26 and tubing was last documented as changed on 3/12/26, which did not match with the dates on R40's humidifying jar and oxygen tubing. LPN-A was starting education for staff who chart without completing the order. During interview on 3/18/26 at 1:30 p.m., the director of nursing (DON) stated nurses were responsible for changing the oxygen tubing and humidifying jars and there were standing orders for the tubing to be changed weekly and the humidifying jars to be changed monthly. The DON further stated this was important for infection control. The facility policy regarding oxygen therapy dated 5/28/24, was received however did not address how often oxygen tubing or humidifying jars should be changed.	F0695		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/18/2026**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/16/26 through 3/18/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	20000		04/20/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER: CERENITY MARIAN OF ST PAUL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 EARL STREET , SAINT PAUL, Minnesota, 55106	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Continued from page 1 The following complaints were reviewed: H53658001C (2796459), H53658580C (2655845) and H53656581C (1139955), and H53655003C (2730410). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20270	Use of Oxygen CFR(s): MN Rule 4658.0090 A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During observation, interview, and document review the facility failed to ensure supplemental oxygen was properly maintained for 1 of 1 resident (R40) reviewed	20270	Resident #40’s humidifier jar was changed on 3/17/2026; the O2 tubing was changed as well. A list of residents receiving oxygen therapy was created; their humidifier jar and O2 tubing are changed per policy. The policy related to respiratory therapy was reviewed. The facility has changed their system for monthly humidifier jar changes and weekly O2 tubing. All humidifiers were changed out on 4/9/2026; going forward, all humidifier jars will be change on the	04/20/2026

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20270	Continued from page 2 for oxygen. Findings include: R40's quarterly Minimum Data Set (MDS) dated 3/6/26, indicated intact cognition and diagnoses of chronic respiratory failure with hypoxia (low oxygenation) and was dependent on supplemental oxygen. R40's physician's orders indicated the following: -on 5/22/25, R40 required continuous oxygen-wean as able per nasal cannula to keep oxygen saturation greater than or equal to 90%. Oxygen at 1 LPM every shift. -on 10/1/25, order directed staff to change and date an oxygen humidifying jar monthly. R40's treatment administration record (TAR) dated 3/2026, indicated R40's humidifying jar was last changed on 3/1/26 and oxygen tubing was changed on 3/12/26. R40's Care plan dated 1/28/25, indicated R40 had ineffective breathing patterns related to chronic respiratory failure with hypoxia, dysphagia (problems swallowing) with aspiration risk. Interventions included: -Administer oxygen per doctor's orders, 1 liter per minute (LPM) via nasal cannula. -Check humidifying jar daily to see if needs fluid. Change humidifying jar and oxygen tubing weekly. -Encourage compliance with oxygen. Check oxygen sats and liter flow every shift as needed/per medical doctor's order. -Monitor portable oxygen concentrators/tanks every shift to make sure tank is not empty. Fill portable tanks per facility policy. -Oxygen as ordered; Measure & document oxygen saturation rates as needed. -Resident likes to take off oxygen on her own. Staff to continue to encourage oxygen use. During observation on 3/16/2026 at 9:09 a.m., R40's oxygen tank (in her room) had a humidifying jar with water in it and was dated 2/1/26. The oxygen tubing had an illegible label that read either 2/8 or 3/8. During observation on 3/17/26 at 11:24 a.m., R40 was in	20270	Continued from page 2 first of the month. Additionally, the facility will change out all tubing on the same day/week. Education was provided to the licensed nurses on our policy and expectation for changing humidifier jars and O2 tubing. Resident's utilizing a humidifier jar will be audited monthly to ensure they are changed per policy. O2 tubing will be audited weekly to ensure that they are changed per policy. The audits will be done each month for 3 months to ensure compliance. Issues identified with respiratory care will be forwarded to the facility's QAPI team for input/suggestion. The Director of Nursing is responsible for ensuring that the humidifier jars and O2 tubing are changed per policy.	

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20270	Continued from page 3 her room with oxygen on. The oxygen tubing in place had an illegible label that read either 2/8 or 3/8. The oxygen tank had a humidifying jar with water in it and was dated 2/1/26. During observation and interview on 3/17/26 at 11:27 a.m., registered nurse (RN)-A confirmed the humidifying jar was dated 2/1/26 and the tubing label was illegible and read either 2/8 or 3/8. RN-A stated the tubing should be changed weekly, and the humidifying jar should be changed monthly. During interview on 3/18/26 at 11:55 a.m., RN-B stated nurses were responsible for changing the oxygen tubing and humidifying jars and the frequency depended on the doctor's orders for each specific resident. During interview on 3/18/26 at 12:00 p.m., RN-C stated nurses were responsible for changing the oxygen tubing and humidifying jars. The oxygen tubing should be changed weekly, and the humidifying jar should be changed monthly. This was determined by the facility's standing orders. During interview on 3/18/26 at 12:05 p.m., licensed practical nurse (LPN)-A stated nurses were responsible for changing the oxygen tubing and humidifying jars and there were standing orders for the tubing to be changed weekly and the humidifying jars to be changed monthly. LPN-A confirmed R40's TAR showed the humidifying jar was last documented as changed on3/1/26 and tubing was last documented as changed on 3/12/26, which did not match with the dates on R40's humidifying jar and oxygen tubing. LPN-A was starting education for staff who chart without completing the order. During interview on 3/18/26 at 1:30 p.m., the director of nursing (DON) stated nurses were responsible for changing the oxygen tubing and humidifying jars and there were standing orders for the tubing to be changed weekly and the humidifying jars to be changed monthly. The DON further stated this was important for infection control. The facility policy regarding oxygen therapy dated 5/28/24, was received however did not address how often oxygen tubing or humidifying jars should be changed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures for oxygen and respiratory equipment to ensure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and	20270		

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20270	Continued from page 4 monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20270		
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure the environment was free of potential hazards for 1 of 1 resident (R56) found to have a space heater operating in their room. Findings include: R56's quarterly Minimum Data Set (MDS) dated 2/5/26, identified moderately impaired cognition and no behaviors. R56 was independent with transfers and ambulation. Diagnoses included cardiopulmonary disease (heart and lung disease), diabetes and cataracts, glaucoma or macular degeneration (eye conditions that cause loss of vision). R56's Mood State care plan dated 3/12/26, identified she had a sleep pattern disturbance related to insomnia and to evaluate her room for noise, darkness, temperature and comfort. During an observation and interview on 3/16/26 at 7:42 a.m., R56 stated her room was too cool and she used a space heater provided to her from nursing. On the laminate style floor was a Holmes brand with model number HFH610 space heater set at 84 degrees on the digital reading. The space heater was blowing warm air and when tipped over did not automatically shut off. R56 stated she usually used the heater only at night. R56 denied being injured by the heater and was unsure how long it had been in her room. During an interview on 3/16/26 at 7:49 a.m., nursing assistant (NA)-A stated residents were not able to have space heaters in their room and was not aware of any in use.	21665	On 3/16/2026 the space heater was immediately removed from resident #56's room. On 3/16/2026 all resident rooms were audited to ensure that no other space heaters were in-use in unauthorized areas. Immediate education began on 3/16/2026 for all staff regarding the prohibitive use of space heaters in resident rooms. Education continued until all staff were re-educated. An audit was completed of space heaters in the building. The existing space heaters were disposed of; we no longer have any space heaters. All purchases are reviewed and approved by the Executive Director; she will monitor for any purchases of space heaters and other prohibited hazards 3 rooms/floor/week will audited to ensure that no prohibited hazards are in the rooms. 2 rooms/floor/week will be audited for the next month. Finally, 1 room/floor/week will be audited for the final month. Issues identified related to space heaters will be referred to the facility's QAPI Team for input/suggestion. The Executive Director is responsible for ensuring that space heaters are not used in resident room/areas.	04/20/2026

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21665	Continued from page 5 During an interview 3/16/26t a 7:51 a.m., registered nurse (RN)-B stated it was okay to give a resident a space heater if they complained of their room being cold. RN-A stated there was a space heater at the nurse's station and was not aware of any space heaters in use currently in resident rooms. During an interview on 3/16/26 at 7:51 a.m., the director of nursing (DON) also stated residents could not have space heaters in their rooms and entered R56's room and removed the space heater. During an interview on 3/17/26 at 11:20 a.m., the administrator stated they do not allow space heaters in resident rooms for safety reasons. The administrator stated the facility did not have a policy because space heaters were not allowed. The undated Product Safety Commission website identified Holmes HFH brand heaters had not been recalled. The Holmes HFH610 instruction manual was not able to be located. The Holmes Official Website - Premium Heaters dated 2026, identified Holmes heaters came with safety features like overheat protection and auto shutoff, and it was always recommended to follow the instruction manual and never leave any heater unattended for long periods while sleeping. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures for space heaters and comfortable environment to ensure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on Cerenity Marian of St. Paul, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, March 18, 2026 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		04/15/2026

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 reverse for further 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.

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: Cerenity Care Center Marian is a 5-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type I(332) construction. In 1969 a 2 story addition was constructed above the 3rd story that was determined to be of type I(332) construction. In 2002 a 1 story addition was constructed to the north that was determined to be Type I(332) construction. In 2019, floors 2, 3, 4 and 5 underwent renovations maintaining Type I (332) construction. The facility has a capacity of 90 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0293 SS = F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K0293	The illuminated exit signage for the 5th floor was ordered and installed. The illuminated exit signs are checked per facility policy. The Environmental Services Director is responsible for ensuring that the illuminated exit signs are working.	04/15/2026

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K0293 SS = F	Continued from page 2 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10.1.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 3/18/2026, at 11:55 AM, it was revealed by observation that there were no exit sign by Stair F on the 5th floor to direct persons to an exit in the event of an emergency. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.	K0293		
K0311 SS = A	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to seal the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition 8.6 and 19.3.1.1. This deficient finding could have an isolated impact on the residents within the facility.	K0311		04/15/2026

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K0311 SS = A	Continued from page 3 Findings Include: On 3/18/2026, at 10:00 AM, observations and staff interview revealed that on the 3rd and 4th floor data closets, there were penetrations through the floor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0311		
K0372 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.7.3. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 3/18/2026 at 12:12 PM, it was revealed by observation that there was a penetration through the smoke wall above the ceiling at Data Closet near the double set of fire doors on the 4th floor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0372	The penetrations through the smoke wall on the 4th floor was fixed. Any penetrations through smoke walls will be fixed. The Director of Environmental Services is responsible for ensuring that there are no penetrations in smoke walls. Identified compliance issues will be referred to the facility's QAPI team for input/suggestions.	04/15/2026
K0511 SS = F	Utilities - Gas and Electric	K0511	The carts in front of the electric panels in the serving kitchen were immediately removed.	04/15/2026

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K0511 SS = F	Continued from page 4 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(A)(F), 110.27(A)(1), 225.19(C) These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 3/18/2026, at 12:00 PM, it was revealed by observation that in the electric panels on the 5th and 3rd floor Kitchens were being blocked by carts. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0511	Continued from page 4 All culinary staff were re-inserviced on not storing carts in front of the electric panels. The culinary director is responsible for ensuring that carts are not stored in front of electric panels in the kitchen area. Identified compliance issues will be referred to the facility's QAPI team for input/suggestions.	
K0920 SS = A Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are	K0920		04/15/2026

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CERENITY MARIAN OF ST PAUL LLC	**200 EARL STREET , SAINT PAUL, Minnesota, 55106**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0920 SS = A Bldg. 01	Continued from page 5 not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 3/18/2026, at 12:20 PM, it was revealed by observation that in the Nursing Station, Clinical Office, there was a refrigerator and a printer plugged into a power strip. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0920		