DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 18, 2026

Administrator
Cerenity Care Center on Humboldt
512 HUMBOLDT AVENUE
SAINT PAUL, MN 55107

RE: CCN:245255

Cycle Start Date: March 5, 2026

Dear Administrator:

On Cycle March 5, 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 5, 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 5, 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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Administrator
Cerenity Care Center on Humboldt
512 HUMBOLDT AVENUE
SAINT PAUL, MN 55107

Re: State Nursing Home Licensing Orders
Event ID: 1E3ED9-H1

Dear Administrator:

The above facility survey was completed on March 5, 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: 245255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Care Center on Humboldt	**512 HUMBOLDT AVENUE , SAINT PAUL, Minnesota, 55107**

(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 3/2/26 through 3/5/26, 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		03/27/2026
F0000	INITIAL COMMENTS On 3/2/26 through 3/5/26, 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: H52557380C (2786523), H52557381C (2725900), H52557382C (2685537), H52557384C (1088061), H52557383C (1088076). 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		03/27/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F0584	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not	04/14/2026

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

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F0584 SS = D	Continued from page 1 The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean, homelike environment for 2 of 2 residents (R45, R2) who received nutrition via tube feeding.	F0584	Continued from page 1 constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. The enteral feeding equipment and pole were cleaned for R45 and R2. A regular cleaning schedule of the enteral feeding equipment was placed in the medical record for both R45 and R2. A facility audit was performed to ensure all residents with enteral feeding equipment had equipment that was clean per policy. A regular cleaning schedule for the enteral feeding equipment was placed in the medical record for all residents with enteral feeding equipment. The Monitoring Residents Receiving Enteral Feedings and Resident Care Equipment policies were revi ewed with no changes. All licensed nursing staff were educated on Monitoring Residents Receiving Enteral Feedings and Resident Care Equipment policies and the enteral feeding equipment schedule. All housekeeping staff were educated on the Resident Care Equipment policy. Audits will be completed on all enteral feeding equipment weekly x 4 weeks and then monthly x 2 months to ensure that the equipment is clean. Results will be brought forward to QAPI to review the need for ongoing auditing. The Director of Nursing or designee is responsible for ongoing compliance. Date of compliance: 4/14/26	

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F0584 SS = D	Continued from page 2 Findings include: R45 R45's admission Minimum Data Set (MDS) dated 10/20/25, indicated R45's cognition could not be assessed, was dependent on staff for all activities of daily living (ADLs), and required nutrition through a feeding tube. R45's diagnosis included traumatic brain injury (a condition resulting from an injury to the head causing disruption of normal brain function and can affect cognition, speech, and physical abilities). R45's care plan dated 10/3/25, indicated potential for altered nutritional/hydration status related to tube feeding. R45's care plan instructed staff to administer tube feeding with water flushes per provider order. R45's care plan further indicated R45 also received an oral diet with modified textures for pleasure or comfort. R45's provider order dated 3/2/26, indicated, "Tube Feeding: Continue with EN [enteral nutrition] support via PEG [percutaneous endoscopic gastrostomy – a tube through the abdomen into the stomach]. Current EN prescription is Osmolite 1.2 at 55 milliliters (ml)l/hour. Water flush of 65 ml/hr. Tube feeding administered continuously using enteral pump." During observation on 3/2/26 at 6:44 p.m., R44 had a tube feeding formula hanging. The tube feeding was attached to R45 via a PEG tube and running. The base of the pole that held the bag of tube feeding formula and water flush, as well as the enteral feeding pump had numerous spots of a dried beige substance which appeared to be tube feeding formula spillage. During observation on 3/3/26 at 10:06 a.m., R44 was in bed with his tube feeding attached and running and still had numerous spots of a dried, beige colored substance on the base of the tube feeding pole. During observation on 3/3/26 at 10:45 a.m., housekeeper (H)-A was in R45's room cleaning. During interview on 3/3/26 at 10:48 a.m., H-A stated she had finished cleaning R45's room. H-A reentered R45's room and confirmed R45's tube feeding pole had a copious amount of tube feeding formula spilled on the base. H-A stated they did not think the tube feeding poles that were in use were her responsibility to clean. H-A stated she would move the pole and clean the floor under the pole, when necessary, but would not	F0584		

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F0584 SS = D	Continued from page 3 touch the pole otherwise while the feeding was running and attached to the resident. H-A further stated, “I don’t know who is supposed to clean it.” R2 R2’s quarterly MDS dated 2/6/26, indicated R2 had severe cognitive impairment, impairment of upper and lower extremities, and was dependent on staff for bed mobility, and transfers. It also indicated R2 required EN and had diagnoses of stroke with hemiplegia (paralysis to one side of the body) and severe protein-calorie malnutrition. R2’s care plan dated 2/1/26, indicated potential for altered nutritional/hydration status related to tube feeding. R2’s care plan instructed staff to administer tube feeding with water flushes per provider order. R2’s care plan further indicated R2 also received an oral diet with modified textures for pleasure or comfort. R2’s physician order dated 2/27/26, indicated, “Tube feeding continue with EN support via G- tube. Current EN prescription was Isosource 1.5, 45ml/hr. Water flush of 25ml/hr. Tube feeding administered continuously using enteral pump.” During observation on 3/2/26 at 4:49 p.m., R2 had tube feeding formula hanging, attached to R2 via G-tube and running. The base and the pole that held the bag of tube feeding formula and water flush, as well as the enteral feeding pump had copious amount of light brown drips and large brown spots of dried liquid on it. During observation on 3/3/26 at 11:20 a.m., R2 was in bed with his tube feeding attached and running and still had copious amounts of dried beige colored substance on the base of the tube feeding pole. During interview on 3/3/26 at 11:39 a.m., housekeeper (H)-B stated they cleaned R2 room, however, housekeeping was not responsible for cleaning R2’s tube feed pole or machine. H-B verified there was a lot of brown dried liquid all over the pole and the base of the pole. The housekeeping cleaning list did not have tube feeding pole listed to clean it. During interview on 3/3/26 at 11:53 a.m., registered nurse (RN)-F stated there was a large amount of dried formula on the machine, pole and base. Furthermore, RN-F had administered R2’s medication this am, however, did not clean the pole or machine.	F0584		

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F0584 SS = D	Continued from page 4 During interview on 3/3/26 at 11:35 a.m., RN-A stated they would expect nursing to wipe up any formula at the time of the spill and that housekeeping could also share the responsibility if a dirty pole was seen when cleaning the resident room. RN-A further stated they would expect residents to have a clean, homelike environment. During interview on 3/3/26 at 3:37 p.m., director of nursing (DON) stated nursing should clean the tube feeding poles when a spill occurs, and that housekeeping could also clean the poles as needed. DON stated would expect residents' dignity to be considered and should and a clean homelike environment provided. Facility policy titled Monitoring Residents Receiving Enteral Feedings dated August 2019, directed the nursing staff to be responsible for the administration of enteral feedings and all feeding equipment. Facility policy titled Resident Care Equipment dated 1/2024, directed staff to ensure IV poles were cleaned when soiled by either housekeeping or nursing.	F0584		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,	F0605	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R8's qualifying diagnosis was received and documented in the medical record. A facility audit will be completed on all residents receiving antipsychotic medications to ensure that there is a qualifying diagnosis in the medical record. The Psychotropic Medication Use policy was reviewed with no changes. All clinical interdisciplinary team members will	04/14/2026

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F0605 SS = D	Continued from page 5 involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure	F0605	Continued from page 5 be educated on the Psychotropic Medication Use Policy and the requirement to have a qualifying diagnosis documented in the medical record. Audits will be completed weekly x4 weeks on newly ordered antipsychotic medications to ensure a qualifying diagnosis is in place. Results will be brought forward to QAPI to review the need for ongoing auditing. The Director of Nursing or designee is responsible for ongoing compliance. Date of compliance: 4/14/2026	

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Cerenity Care Center on Humboldt	**512 HUMBOLDT AVENUE , SAINT PAUL, Minnesota, 55107**

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F0605 SS = D	Continued from page 6 that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure an antipsychotic medication (medication that works by changing the effects of chemicals in the brain) had a qualifying diagnosis to support its use for 1 of 5 residents (R8) reviewed who required antipsychotic medications Findings include: R8's quarterly Minimum Data Set (MDS) dated 2/17/26, identified moderate cognitive impairment. R8 did not hallucinate, have delusions, behaviors, wander or reject care during the assessment period. R8 took an antipsychotic medication in the last seven days, and an indication was noted.	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Care Center on Humboldt	512 HUMBOLDT AVENUE , SAINT PAUL, Minnesota, 55107

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F0605 SS = D	Continued from page 7 R8's psychotropic drug use care plan dated 2/27/26, identified psychotropic medication was in use, to administer medications per MD (medical doctor) order, monthly medication record review by pharmacist, and monitor for target behaviors daily. R8's provider orders dated 9/17/25, identified Risperdal (risperidone, an antipsychotic medication) two milligrams (mg) tablets by mouth at bedtime for a diagnosis of major depressive disorder, single episode, mild. R8's available Associated Clinic of Psychiatry (ACP) visits dated 10/28/25, 10/31/25, 11/20/25, 12/1/25, 1/9/26, and 1/23/26, lacked a diagnosis associated with Risperdal use. R8's Consultant Pharmacist (CP) recommendation to physician dated 8/23/25, and 1/19/26, identified R8 received an antipsychotic medication Risperdal 2 mg at bedtime for MDD (major depressive disorder, mild) and a qualifying diagnosis to support its use was not documented. Per CMS (Center for Medicaid and Medicare Services) guidelines and DSM-5 (Diagnostic and Statistical Manual of Mental Disorder) diagnostic criteria, antipsychotic medications are generally appropriate only when used to treat the following conditions:Schizophrenia spectrum disorders (e.g. schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder)Bipolar I or II disorders with manic, mixed or psychotic features.Major depressive disorder with psychotic featuresRefractory major depressionBrief psychotic disorderPsychotic disorder due to another medical condition (e.g. delirium with psychotic features)Other specified or unspecified schizophrenia spectrum and psychotic disorders.During an interview on 3/5/26 at 12:15 p.m., the director of nursing (DON) stated R8's diagnosis should come from ACP psychiatry and not the primary care provider. The DON stated the facility policy was to print the recommendation and follow up right away by giving the recommendation to the provider. The DON stated there was no documentation the facility followed up with the ACP provider to obtain a qualifying diagnosis. The DON did not identify what types of qualifying diagnoses applied to antipsychotic medications. During an email on 3/5/26 at 1:09 p.m., the CP identified she was not available for phone calls. The CP's email response identified R8's' psychiatric services were managed by ACP. In situations where outside psychiatric providers oversee psychotropic	F0605		

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F0605 SS = D	Continued from page 8 management, the facility appropriately forwards consultant pharmacist recommendations to the prescribing provider by fax for review. The facility's Psychotropic Medication Use policy dated 9/7/23, directed the DON to implement the policy to ensure psychotropic medications were ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record. Additionally, the nursing associates would collaborate with the medical providers to ensure the lowest possible dosage was given for the shortest period. The policy lacked the process to review qualifying diagnoses for antipsychotic medications.	F0605		
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 - §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 manufacturer's recommended sling size was used for 1 of 1 resident (R79) reviewed for mechanical lift transfers. Findings include: R79's quarterly Minimum Data Set (MDS) dated 12/16/25, identified severely impaired cognition and no behaviors. R79 had impairment to upper and lower extremities, was dependent staff for bed to chair transfers and had a diagnosis of traumatic brain dysfunction. R79 had no falls since the prior assessment. R79's admission Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 9/17/25, identified the CAA triggered due to assistance required in ADLs, impaired balance and transition during transfers and functional impairment in activity. Contributing factors included generalized weakness.	F0689	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R79 is currently using an appropriately sized sling. All residents that use mechanical lifts have been reviewed and are using appropriately sized slings. The Mechanical lift policy was reviewed with no changes made. All nursing and therapy staff have been educated on the Using a Mechanical Lift policy, and the steps in the procedure as indicated in the policy. 8 residents per week x 4 weeks will be audited for correct sling size use. Then 4 residents per week x 4 weeks. Then 2 residents per week x 4 weeks. Results will be brought forward to QAPI to review the need for ongoing auditing. The Director of Nursing or designee is responsible for ongoing compliance.	04/14/2026

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F0689 SS = D	Continued from page 9 R79's ADL care plan dated 9/11/25, identified two staff assist was required with full body mechanical lift with a sling size of medium. R79's Safe Lifting and Movement assessment dated 11/14/25, identified he could not stand for eight seconds without any devices, had unpredictable behavior changes frequently and was unable to follow simple commands. R79 required two person transfers with full body mechanical lift and R79's height was five feet seven inches and most recent weight was 155 pounds. During an observation and interview on 3/2/26 at 3:24 p.m., nursing assistant (NA)-A positioned an EZ Lift brand full body sling with maroon straps under R79 while he sat in his wheelchair. NA-A had not looked at the sling label for size, and positioned the sling behind R79's back, brought the leg straps under R79's legs, crossed the straps, connected the sling to EZ Lift model 798 (full body mechanical lift) and connected the longer lower loop to the EZ Lift hooks. NA-B connected the upper loops using the lower strap to the EZ lift hooks. NA-A raised R79 in the sling out of R79's wheelchair, pushed the lift over to the bed, lowered R79 to the bed and NA-A and NA-B lowered the sling to the bed and removed the sling from under R79. During the transfer R79's body was tilted to the right, instead of straight up and down, and his left hip and buttocks hung down through the sling seat opening area. When asked what sling size was used, NA-A picked up the sling that was removed and read the label which read size large. NA-A stated he should have checked the sling size before completing the transfer. NA-A removed the sling from R79's room as it was soiled. During a follow up interview on 3/2/26 at 5:38 p.m., NA-B stated staff should reference the care card for mechanical lift sling sizes. NA-B presented the care card which specified a medium sling should have been used. NA-B stated sometimes if a resident had a shower and the sling got wet, staff would have to use what was available. NA-B confirmed she was with Na-A during the transfer, and the sling size was not checked. During an interview on 3/2/26 at 5:43 p.m., registered nurse (RN)-B stated mechanical lift sling size was the responsibility of the managers and the staff should reference the resident care cards. RN-B presented R79's care card which identified he needed a medium body sling. RN-B stated she would look for a medium sling, since NA-A brought the sling to the laundry and no sling was currently available.	F0689	Continued from page 9 Date of compliance: 4/14/2026	

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F0689 SS = D	Continued from page 10 During an interview on 3/4/26 at 2:38 p.m., the director of nursing (DON) stated therapy would establish sling size for residents and communicate with the managers so the care cards could be updated. The purpose of appropriately sizing a sling was to prevent accidents due to unsafe equipment. During an interview on 3/5/26 at 11:53 a.m., the physical therapist (PT) verified R79 should use a medium size sling to ensure transfers are stable. The EZ Way Sling Size Chart (form #2-150) dated 9/13/24, identified a large sling (burgundy straps) should be used for resident weight of 190 to 330 pounds and maximum distance from tailbone to base of neck of 26 inches, and medium sling size (beige straps) should be used for resident weight of 90 to 220 pounds and maximum distance from tailbone to base of neck 24 inches. The facility's undated policy titled Using a Mechanical Lift, identified a resident needed to be measured for proper sling size and purpose according to manufacturer's instructions and to double check the sling and machine's weight limit against the resident's weight. After placing the sling under the resident, visually check the size to ensure it is not too large or too small.	F0689		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting,	F0693	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R45's tube feeding formula rate was adjusted to the prescribed amount, and the provider order was updated in medical record. A facility audit was completed on all residents with an enteral tube feeding to ensure the provider's orders were reflective of the registered dietitian recommendations.	04/14/2026

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F0693 SS = D	Continued from page 11 dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure administration of tube feeding formula according to provider orders for 1 of 1 resident (R45) reviewed for tube feeding. Findings include: R45's admission Minimum Data Set (MDS) dated 10/20/25, indicated R45's cognition could not be assessed, was dependent on staff for all activities of daily living (ADLs), and required nutrition through a feeding tube. R45's diagnosis included traumatic brain injury (a condition resulting from an injury to the head causing disruption of normal brain function and can affect cognition, speech, and physical abilities). R45's care plan dated 10/3/25, indicated potential for altered nutritional/hydration status related to tube feeding. R45's care plan instructed staff to administer tube feeding with water flushes per provider order. R45's care plan further indicated R45 also received an oral diet with modified textures for pleasure or comfort. R45's nutrition progress note by registered dietician (RD) dated 3/2/26 at 2:54 p.m., indicated R45 experienced a weight gain since admission of 15 pounds which was contributed to good oral intake combined with tube feeding formula running at 75 milliliters an hour (ml/hr) continuously for 24 hours with water flushes of 65 ml/hr over 24 hours. R45's progress note indicated RD ordered a reduction in the tube feeding rate to 55 ml/hr and continued the water flushes as previously ordered. R45's provider order dated 3/2/26, indicated, "Tube Feeding: Continue with EN [enteral nutrition] support via PEG [percutaneous endoscopic gastrostomy – a tube through the abdomen into the stomach]. Current EN prescription is Osmolite 1.2 at 55 ml/hour. Water flush of 65 ml/hr. Tube feeding administered continuously using enteral pump." R45's March 2026, medication administration record (MAR) printed on 3/3/26 at 10:20 a.m., indicated R45's tube feeding of 55 ml/hr with water flushes at 65 ml/hr was signed off as completed on 3/2/26 shift 2 (evenings) and shift 3 (nights), and 3/3/26 shift 1 (days). R45's MAR further indicated the tube feeding at	F0693	Continued from page 11 The Monitoring Residents Receiving Enteral Feedings policy was reviewed with no changes. All licensed nurses and registered dietitian were reeducated on the provider order transcription process and Monitoring Residents Receiving Enteral Feedings policy. Audits will be completed on all residents with eternal tube feeding orders weekly x 4 weeks and monthly x 2 months. Results will be brought forward to QAPI to review the need for ongoing auditing. The Director of Nursing or Designee is responsible for ongoing compliance. Date of compliance: 4/14/2026	

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F0693 SS = D	Continued from page 12 70 ml/hr with 65 ml/hr water flush was not given on 3/2/26 at 3:40 p.m., due to being discontinued. During observation on 3/2/26 at 6:44 p.m., R45's tube feeding was running at 70 ml/hr. During observation 3/3/26 at 10:06 a.m., R45's tube feeding was running at 70 ml/hr. The tube feeding formula was labelled 3/3/26 1:30 a.m. During interview on 3/3/26 at 10:32 a.m., licensed practical nurse (LPN)-A stated when a resident received continuous tube feeding and water flushes, the formula and water bags were changed when they ran out. LPN-A stated R45's tube feeding was running at 70 ml/hr as it had been for quite some time. LPN-A stated they just replaced the bags as needed and did not adjust the rate since the rate never changed. LPN-A looked in R45's electronic medical record (EMAR) and verbally verified R45 had a new order for his tube feeding to run at 55 ml/hr instead of 70 ml/hr. LPN-A entered R45's room and confirmed R45's tube feeding was running at 70 ml/hr and it was not running as ordered. LPN-A stated when a new order was placed, a second nurse had to verify the order in the EMAR prior to the first administration of the new order. During interview on 3/3/26 at 2:40 p.m., LPN-B stated he verified R45's new order of 55 ml/hr in the EMAR on 3/2/26 at the start of the evening shift but did not hang a new bag on his shift. LPN-B stated he signed off the tube feeding in the EMAR for his shift to indicate the rate had been confirmed but stated he did not visually confirm the rate at which R45's tube feeding was running. LPN-B could not explain why he was not aware of the new rate even though he had verified the new order in the EMAR. During interview on 3/3/26 at 2:47 p.m., registered nurse (RN)-A expected nurses to follow orders as written and would not expect nurses to sign off medication administration or treatments if not actually completed. RN-A stated orders should be verified by a second nurse. The nurse who verified the order would sign off the order as verified prior to any administration or treatment. During interview on 3/3/26 at 3:37 p.m., director of nursing (DON) expected nursing staff to follow provider orders as written and not sign off items on the MAR or TAR if not actually completed. During interview on 3/4/26 at 1:54 p.m., RD stated would expect orders to be followed as entered. RD	F0693		

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F0693 SS = D	Continued from page 13 stated R45's tube feeding rate had been changed on 3/2/26, to a lower rate due to his weight gain and would expect nurses to have changed the rate with the most recent administration. A facility policy titled Monitoring Residents Receiving Enteral Feedings dated August 2019, indicated residents who receive enteral feeding will receive appropriate treatment.	F0693		
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: Based on observation, interview and document review, the facility failed to ensure respiratory equipment was properly maintained for 1 of 1 resident (R44) reviewed for respiratory care. Findings include: R44's admission Minimum Data Set (MDS) dated 1/14/26, indicated R44 had intact cognition, required partial/moderate assistance with most activities of daily living (ADLs), and required oxygen therapy while a resident. R44's diagnoses included chronic respiratory failure, congestive heart failure (CHF) and dependence on supplemental oxygen. R44's care plan dated 1/15/26, indicated R44 required special treatments including oxygen therapy. R44's treatment administration record (TAR) dated 2/15/26 through 3/2/26, indicated, "Change humidifying jar [bubbler] weekly…once a day on Sun." The TAR indicated the task was signed off as completed on 2/15/26, 2/22/26, and 3/1/26.	F0695	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R44's respiratory equipment was changed and dated per policy. A facility audit was completed on all residents with oxygen orders and verification that the equipment was properly maintained per policy. The Cleaning of Oxygen Equipment policy was reviewed with no changes. All licensed nurses were educated on the Cleaning of Oxygen Equipment Policy and how to properly maintain oxygen equipment. Audits of oxygen equipment will be completed weekly x4 weeks and then monthly x2 months on all residents with oxygen orders to ensure equipment is properly maintained. Results will be brought forward to QAPI to review the need for ongoing auditing. The Director of Nursing or designee is responsible for ongoing compliance.	04/14/2026

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F0695 SS = D	Continued from page 14 During observation on 3/2/26 at 1:35 p.m., R44 was in her room in a wheelchair with oxygen administered via nasal canula at 2 liters per minute. The undated oxygen tubing was attached and running through a bubbler. The bubbler was labeled, "2/15 JMD." During interview on 3/2/26 at 1:51 p.m., licensed practical nurse (LPN)-C stated oxygen tubing and bubbler were changed once a week by the nurse. LPN-C stated she forgot to change R44's bubbler yesterday (3/1/26). Further, she verified she should not have signed it off as being completed since she did not complete the task outlined on the TAR. LPN-C confirmed R44's oxygen tubing was not dated, and the bubbler was dated 2/15. LPN-C could not confirm when the tubing had last been changed and could not explain why the bubbler was signed off as changed on 2/22/26 and still had the 2/15 date on it. During interview on 3/3/26 at 2:47 p.m., registered nurse (RN)-A expected nurses to follow orders as written and would not expect nurses to sign off medication administrations or treatments if they were not actually completed. RN-A further stated R44's oxygen tubing and bubbler should be changed weekly to prevent any respiratory infections. During interview on 3/3/26 at 3:37 p.m., director of nursing (DON) stated staff were expected to follow provider orders as written and not sign off items on the medication administration record (MAR) or TAR if not actually completed. Facility policy Cleaning of Oxygen Equipment dated June 2017, identified purpose to reduce the risk of infections and directed staff to replace oxygen tubing and humidifier bottle once a week and to use tape to place date and initials on tubing and bottle when replaced.	F0695	Continued from page 14 Date of compliance: 4/14/2026	
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if	F0755	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	04/14/2026

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F0755 SS = D	Continued from page 15 State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure new medication orders were transcribed correctly to ensure accurate medication administration for 1 of 1 resident (R79) who was reviewed for recent medication changes. Findings include: R79's quarterly Minimum Data Set (MDS) dated 12/16/25, identified severely impaired cognition and no behaviors. R79 had impairment to upper and lower extremities, was dependent on staff for bed to chair transfers and had a diagnosis of traumatic brain dysfunction. R79's Cognitive loss/Dementia care plan dated 1/20/26, identified a diagnosis of cognitive loss from a traumatic brain dysfunction. R79 would receive services and assistance needed specific to his cognitive function. R79's family member assisted with decision making. R79's hospital After Visit Summary (AVS) dated 2/27/26	F0755	Continued from page 15 The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R79's medication orders were updated and accurately transcribed into the medical record. All residents with medication orders were audited to ensure orders were transcribed accurately. All licensed nurses and health information staff to be educated on order transcription process. Audits to be completed on any newly admitted or readmitted residents weekly x4 weeks and then monthly x2 months. Results will be brought forward to QAPI to review the need for ongoing auditing. The Director of Nursing or designee is responsible for ongoing compliance. Date of compliance: 4/14/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Care Center on Humboldt	512 HUMBOLDT AVENUE , SAINT PAUL, Minnesota, 55107

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F0755 SS = D	Continued from page 16 at 9:53 p.m., identified he was seen due to redness of skin, seizure like activity and fever. Instructions included to “stop taking lacosamide” which is an anti-seizure medication, and to start taking levetiracetam (Keppra) which is a different antiseizure medication; take 500 milligrams (mg) by mouth two times a day for 14 days. R79’s undated active orders included: -Start date of 2/25/25, lacosamide 100 mg tablet by mouth two times a day. -Start date of 2/28/26, levetiracetam 500 mg tablet by mouth two times a day for 14 days. R79’s medication administration record dated 2/25/26 through 3/2/26, identified lacosamide 100 mg by mouth twice daily was documented as held due to R79’s emergency department (ED) visit on the evening of 2/27/26, refused the morning of 2/28/26, on hold per report the evening of 2/28/26, refused the morning of 3/1/26, and on hold the evening of 3/1/26. The medication was administered the morning of 3/2/26. The medication was not discontinued from R79’s medical record on 2/27/26, as ordered in the AVS. During an interview on 3/2/26 at 12:16 p.m., R79’s family member (FM)-A stated last week R79 had what looked like a seizure, went to the hospital to be evaluated and was started on lacosamide (an antiseizure medication). A couple of days later R79 went to the hospital again with a suspected reaction to the lacosamide which included a new rash and lip swelling. The hospital doctor discontinued the lacosamide and started a new anti-seizure medication and R79 returned to the facility. During an observation and interview on 3/2/26 at 3:45 p.m., licensed practical nurse (LPN)-G and registered nurse (RN)-E entered R79’s room with one yellow shaped pill and stated it was R79’s lacosamide. FM-A stated the lacosamide was discontinued and showed R79’s AVS dated 2/27/26, which identified the medication was discontinued. LPN-G and RN-E left R79’s room and went to the nurse’s cart. At the cart, the lacosamide 100 mg was verified as the pill brought into R79’s room. FM-A brought the AVS up to the nurse’s cart and LPN-G and RN-E verified the AVS FM-A had, matched the AVS which was uploaded in R79’s electronic medical record (EMR). FM-A stated there were no signs of current allergy. During a follow up interview on 3/2/26 at 3:55 p.m., registered nurse (RN)-E verified lacosamide was an	F0755		

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F0755 SS = D	Continued from page 17 active order and the previous nurse should have discontinued the medication from the system and not documented as refused or held. RN-E stated he called R79's primary care provider and was awaiting a return call. During an interview on 3/2/26 at 4:12 p.m., RN-B stated after hours, and on weekends, new orders were to be transcribed into the medical record by a nurse and verified by another nurse. RN-B reviewed R79's AVS and stated the order should have been discontinued from R79's EMR. RN-B stated the interdisciplinary team reviewed R79's emergency room visit but had not looked to see if the new orders had been implemented correctly. During an interview on 3/3/26 at 2:58 p.m., LPN-E stated she worked with R79 on the weekend. On weekends and after hours the nurse on duty would update orders into the EMR and a second nurse would verify the orders. LPN-E stated she held the medication on the weekend due to family request. LPN-E stated the medication should have been discontinued from the EMR once the new orders were received. During an interview on 3/4/26 at 9:19 a.m., the nurse practitioner (NP) stated she was updated on 3/2/26, about the medication transcription error and that R79 received an extra dose after the lacosamide was discontinued. The NP would have expected the medication to be transcribed as ordered. Additionally, the transcription error was not serious because after the medication was discontinued, only one extra dose was administered. NP-A stated she was unsure of lacosamide being a true allergy at this time. During an interview on 3/4/26 at 2:58 p.m., RN-C stated she worked on 2/27/26, in the evening when R79 returned from the emergency department. RN-C stated she entered the new order for Keppra into R79's EMR, however did not see the new order to stop the lacosamide. During an interview on 3/5/26 at 12:22 p.m., the director of nursing (DON) stated he expected two nurses to verify new medication orders for accuracy. New orders for a resident should be reviewed and implemented as soon as possible. The DON stated the order was missed on the AVS at the time of R79's return, and subsequent nurses had not reviewed the original AVS. A medication transcription policy was not obtained on survey.	F0755		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On	F0756	This plan of correction constitutes the facility's	04/14/2026

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F0756 SS = D	Continued from page 18 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were followed up timely for 1 of 5 residents (R8) reviewed for unnecessary medications.	F0756	Continued from page 18 credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R8’s pharmacy recommendation was completed and uploaded into the medical record. All residents with pharmacy recommendations will be audited for completion. Director of nursing and clinical managers have been educated on timely completion of pharmacy recommendations. An audit will be completed monthly for 3 months on all new pharmacy recommendations to ensure timely completion. Results will be brought forward to QAPI to review the need for ongoing auditing. The Director of Nursing or designee is responsible for ongoing compliance. Date of compliance: 4/14/2026	

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F0756 SS = D	Continued from page 19 Findings include: R8's quarterly Minimum Data Set (MDS) dated 2/17/26, identified moderate cognitive impairment. R8 did not hallucinate, have delusions, behaviors, wander or reject care during the assessment period. R8 took an antipsychotic medication (medication that works by changing the effects of chemicals in the brain) in the last seven days, and an indication was noted. R8's psychotropic drug use care plan dated 2/27/26, identified psychotropic medication was in use, to administer medications per MD (medical doctor) order, monthly medication record review by pharmacist, and monitor for target behaviors daily. R8's prescription orders dated 9/17/25, identified Risperdal (risperidone. antipsychotic medication) two milligrams (mg) tablets by mouth at bedtime for a diagnosis of major depressive disorder, single episode, mild. R8's available Associated Clinic of Psychiatry (ACP) visits dated 10/28/25, 10/31/25, 11/20/25, 12/1/25, 1/9/26, and 1/23/26 lacked a diagnosis for Risperdal. R8's Consultant Pharmacist (CP) Recommendation to Physician dated 8/23/25, and 1/19/26, identified R8 received an antipsychotic medication Risperdal (risperidone) 2 mg at bedtime (HS), for MDD (major depressive disorder, mild) and a qualifying diagnosis to support its use was not documented. Per CMS (Centers for Medicaid and Medicare Services) guidelines and DSM-5 (Diagnostic and Statistical Manual of Mental Disorder) diagnostic criteria, antipsychotic medications are generally appropriate only when used to treat the following conditions:Schizophrenia spectrum disorders (e.g. schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder)Bipolar I or II disorders with manic, mixed or psychotic features.Major depressive disorder with psychotic featuresRefractory major depressionBrief psychotic disorderPsychotic disorder due to another medical condition (e.g. delirium with psychotic features)Other specified or unspecified schizophrenia spectrum and psychotic disorders.R8's electronic medical record lacked indication the facility had followed up on the CP recommendations from 8/23/25 or 1/19/26. Follow up for R8's CP recommendations for 8/23/25 and 1/19/26 were requested, however were not received. The CP issued the recommendations first on 8/23/25, and	F0756		

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F0756 SS = D	Continued from page 20 again on 1/19/26, and it was still not addressed 3/5/26, which was 6 months and 10 days after the initial recommendation. During an interview on 3/5/26 at 12:15 p.m., the director of nursing (DON) stated R8's diagnosis should come from ACP psychiatry and not the primary care provider. Additionally, CP recommendations should be followed upon monthly unless otherwise indicated by the CP. The DON stated the facility policy was to print the recommendation and follow up right away by giving the recommendation to the provider. The DON stated there was no documentation the facility attempted to follow up with the ACP provider to obtain a qualifying diagnosis. During an email on 3/4/26 at 2:33 p.m., the CP identified she was not available for phone calls. The expectation was that clinical staff respond in a timely manner either accepting the recommendation or providing patient specific clinical rationale as to why the recommendation was declined. Communication via email on 3/5/26 at 1:09 p.m., the CP identified she was not available for phone calls. The email response identified timely follow-up and resolution of CP recommendations were routinely emphasized through ongoing collaboration with facility leadership. During Quality Assurance and Performance Improvement (QAPI) meetings and routine discussions with the DON, the importance of reviewing and responding to recommendations in a timely manner was reinforced. For R8, the initial recommendation was made in August. Follow-up communication was provided via email to the DON in October, and the recommendation was re-sent in January to ensure continued review. The residents' psychiatric services were managed by ACP. In situations where outside psychiatric providers oversaw psychotropic management, the facility was expected to forward the recommendations to the prescribing provider by fax for review. When monitoring response timelines, the CP took these additional communication steps and the involvement of outside specialty providers into consideration, while continuing to follow up as needed to support appropriate medication management. The facility's Psychotropic Medication Use policy dated 9/7/23, identified the DON was responsible for implementation of this policy. Psychotropic medications were ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record. Additionally, the nursing associates would collaborate with the medical providers to ensure the lowest possible dosage was given for the shortest	F0756		

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F0756 SS = D	Continued from page 21 period. The policy lacked the process to review qualifying diagnoses for antipsychotic medications. The facility's Consultant Pharmacist Services Provider Requirements dated 12/17, indicated a written or electronic report of findings and recommendations would be completed monthly and the facility had a process to ensure the findings were acted upon.	F0756		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Enhanced barrier precautions (EBP) are being followed per policy for R2 and R19. Enhanced barrier precautions (EBP) will be followed per policy for all residents where EBP is indicated. The Enhanced Barrier Precautions policy was reviewed with no updates. All nursing and therapy staff will be reeducated on Enhanced Barrier Precaution use and the EBP Policy. Audits of EBP use will be completed on residents where EBP are indicated three times a week for x 4 weeks and then weekly x 2 months. Results will be brought forward to QAPI to review the need for ongoing auditing. The Director of Nursing or Designee is responsible for ongoing compliance. Date of compliance: 4/14/2026	04/14/2026

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F0880 SS = D	Continued from page 22 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to implement enhanced barrier precautions (EBP) for 2 of 2 residents (R19 and R2) observed for EBP. Findings include: R19 R19's comprehensive Minimum Data Set (MDS) dated 12/11/25, identified moderately impaired cognition, no behaviors or rejection of care. R19 required substantial/maximal assistance with eating, bathing and dressing. Diagnoses included orthopedic aftercare. R19 had two unhealed pressure ulcers classified as unstageable (wounds where the extent of tissue damage	F0880		

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F0880 SS = D	Continued from page 23 cannot be identified) and present upon admission. R19's admission pressure ulcer Care Area Assessment (CAA) dated 12/17/25, triggered due to actual pressure ulcers. Care plan interventions would be initiated to improve current activities of daily living status and functional ability. R19's care plan dated 2/14/26, identified he was on EBP for osteomyelitis (bone infection) and presence of a wound. Interventions included implement EBP according to facility protocol. Clear signage would be posted on the door to indicate the presence of personal protective equipment (PPE) requirements. Staff were directed to apply gloves and gown prior to high-contact care activities. R19's medication orders dated 3/2/26 through 3/29/26, identified give one-gram meropenem (antibiotic medication) intravenous (IV) solution twice daily for a diagnosis of osteomyelitis. During an observation and interview on 3/4/26 at 8:29 a.m., licensed practical nurse (LPN)-H prepared R19's 8:00 a.m., dosage of IV meropenem while LPN-C observed. LPN-H stated R19 had a peripherally inserted central catheter (PICC); a type of central line which delivers medication via IV. During an observation and interview on 3/4/26 at 8:45 a.m., R19's room door had a sign directing EBP were in place. The EBP door sign identified: Wear gloves and a gown for high-contact resident care activities such as device care or use of a central line. A PPE bin was located outside the door containing gloves and gowns. LPN-H donned (put on) gloves from the PPE bin, but no gown, and entered R19's room. LPN-H raised R19's head of bed, set a pill cup on the bedside table, administered pills and then the inhaler. LPN-H then doffed (removed) the used gloves and donned new gloves, cleaned R19's PICC line port with an alcohol wipe, and flushed the PICC line with 10 milliliters(mL) of normal saline. LPN-B was present in the room observing. At 8:56 a.m., LPN-H hung R19's meropenem on the IV pole, and the surveyor stopped the procedure. When asked if any other PPE was required for PICC line care, LPN-B and LPN-H reviewed the sign on the room door which identified a gown and gloves should be worn during PICC line care. LPN-B asked LPN-H to don PPE. LPN-H removed his gloves, exited the room, used an alcohol-based hand rub, donned a gown and gloves and reentered the room to administer R19's IV antibiotic as ordered. At 9:05 a.m., LPN-H doffed his PPE, used an alcohol-based hand rub and exited R19's room. LPN-H stated he did not	F0880		

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F0880 SS = D	Continued from page 24 notice the sign on the door with the PPE requirements but had received training upon hire on the process. R2 R2's quarterly MDS dated 2/6/26, indicated R2 had severe cognitive impairment, impairment of upper and lower extremities, and was dependent on staff for total body care, bed mobility, and transfers. It also indicated R2 had enteral feeding (administer liquid nutrition and medication in a tube in abdomen), diagnoses of stroke with hemiplegia (paralysis to one side of the body) and severe protein-calorie malnutrition. R2's physician orders dated 8/4/25, indicated R2 required care for feeding tube: wash around tube daily and as needed, with warm water and cloth, apply sterile split gauze around site, and secure in place as needed. R2 further required EBP to be implemented for cares of R2. R2's care plan dated 8/10/25, indicated R2 had an enteral nutrition via a feeding tube. Interventions included EBP according to facility protocol. Post clear signage on the door or wall outside of resident room and required personal protective equipment. During observation on 3/4/26 at 7:55 a.m., R2's door sign stated enhanced barrier precautions and directed staff to use gown and gloves during high contact cares. Outside of R2's room was a cart with PPE that included gowns and gloves. Registered nurse (RN)-D completed hand hygiene, donned gloves and entered R2's room without donning a gown. RN-D disconnected R2's tube feeding, administered medications and flushes and reconnected R2's tube feeding. RN-D then took off the old dressing from the feeding tube site, cleaned the tube site and placed a new dressing. During observation and interview on 3/4/26 at 8:13 a.m., nursing assistant (NA)-D and NA-F had entered R2's room to assist R2 with personal cares. Without gowns on, NA-D and NA-F rolled R2 side to side and proceeded to change R2's linen and soiled brief. NA-D stated it was not necessary to wear EBP such as a gown during personal cares with R2. After cares were completed, NA-D verified R2 had a EBP sign on door with PPE equipment cart outside of the room directing them to wear gown and gloves with close contact cares. During interview on 3/4/26 at 1:43 p.m., NA-F stated EBP not necessary unless touching or doing direct cares	F0880		

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F0880 SS = D	Continued from page 25 with R2's feeding tube. A gown wasn't necessary to wear, but gloves were when providing personal cares with R2. During interview on 3/4/26 at 1:58 p.m., RN-D stated PPE was to be worn according to the signage on residents' door. EBP could include a mask, gown and gloves. EBP was used in cares that included dressing changes, tube feedings and personal care. RN-D verified she did not wear a gown when completing R2's tube feeding cares and medication administration. Furthermore, EBP was used to decrease risk of infections. During interview on 3/5/26 at 11:33a.m., infection preventionist (IP) stated they expected staff to don gown and gloves for any cares/contact with residents who required EBP. This included IV medication administration, personal cares and tube feeding cares. During interview on 3/5/26 at 1:31 p.m., director of nursing (DON) stated staff were expected to wear proper PPE when doing personal or direct cares with residents on EBP. They were to wear gloves, gown and mask. The information was on the sign on the residents' door. EBP was to be utilized to prevent cross contamination and prevent infections from spreading. A policy titled Enhanced Barrier Precautions dated 4/1/24, directed staff to use EBP in situations in which exposure to blood and body fluids is anticipated and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP were also used for residents with indwelling medical devices, central lines, hemodialysis catheters, feeding tubes and indwelling urinary catheters. High-contact resident care activities included transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, changing linens, indwelling urinary catheter, and wound care. EBP were intended to be used for the duration of a resident's stay.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245255	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on March 3, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cerenity Care Center on Humbolt 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		03/27/2026

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: 245255	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

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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: The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. Because the original building and the addition meet the construction type allowed for existing buildings, it was surveyed as one building. The facility has a capacity of 93 beds and had a census of 80 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0351 SS = F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K0351	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	04/14/2026

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K0351 SS = F	Continued from page 2 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 19.3.5.4, and 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.6.6.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 3/3/2026 at 10:15 AM, it was revealed by observation and staff interview that there were items in contact with the automatic sprinkler system above the ceiling near the double doors by the Nutrition Center on the 3rd floor and in the elevator lobby in the 2nd floor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0351	Continued from page 2 The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Items in contact with automatic sprinkler system above the ceiling near the double doors by the nutrition center on the 3rd floor and in the elevator lobby on the 2nd floor were removed. All hallway sprinkler heads have been audited to ensure no items were in contact with the sprinkler system. EVS Director or designee will audit three sprinkler heads per week for four weeks, and then three sprinkler heads per month for two months. EVS Director or designee is responsible for ongoing compliance Date of compliance: 4/14/26	
K0541 SS = F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING	K0541	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	04/14/2026

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K0541 SS = F	Continued from page 3 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), section 5.2.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 3/3/2026, at 10:30 AM, it was revealed by observation in that the soiled utility room on the 1st floor, there was no fusible link that would close off the chute in the event of a fire. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0541	Continued from page 3 The plan of correction is prepared and/or executed in accordance with federal and state law requirements. A fusible link has been added to the laundry chute in the soiled utility room on the 1st floor so that the chute will close off in the event of a fire. Chute doors in the facility were audited to ensure closure during the event of a fire emergency. Item has been added to the fire damper inspection schedule. EVS Director or designee will monitor to ensure continued compliance. EVS Director or designee is responsible for ongoing compliance. Date of compliance: 4/14/26	
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and	K0918	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	04/14/2026

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K0918 SS = F Bldg. 01	Continued from page 4 associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on documentation review and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 3/3/2026, at 9:45 AM, it was revealed by a review of available documentation and interview with staff that the facility was not testing the emergency generator batteries for specific gravity or conductance on a monthly basis. Additionally, there was no documentation to show that the fuel was being tested annually. An interview with the Maintenance Director verified	K0918	Continued from page 4 The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Conductance tester for battery testing purchased. Monthly test for emergency generator batteries was completed. Annual fuel test completed on 3/27/26. A monthly emergency battery testing task has been added to the monthly generator testing log for ongoing compliance. Annual fuel testing regulatory task added to plant operations management platform. Generator testing log will be audited every month, for three months. EVS Director or designee is responsible for ongoing compliance. Date of compliance: 4/14/26	

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K0918 SS = F Bldg. 01	Continued from page 5 this deficient finding at the time of discovery.	K0918		