DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 1PS4
Facility ID: 00538

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245255**

2. STATE VENDOR OR MEDICAID NO.
(L2) **044518500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER ON HUMBOLDT**
(L4) **512 HUMBOLDT AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55107**

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/10/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **117** (L18)

13. Total Certified Beds **117** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With
Program Requirements
Compliance Based On:

___ 1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	117			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 01/03/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/03/2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY

X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/13/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2021
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 3, 2022

CMS Certification Number (CCN): 245255

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 7, 2021 the above facility is certified for:

117 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 117 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Delivered
January 3, 2022

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: CCN: 245255
Cycle Start Date: October 7, 2021

Dear Administrator:

On December 10, 2021, 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, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00538

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5. Validation 6. Complaint
7. On-Site Visit 9. Other
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FISCAL YEAR ENDING DATE: (L35) **06/30**

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And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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Sarah Grebenc, Unit Supervisor 11/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/03/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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22. ORIGINAL DATE OF PARTICIPATION **09/13/1982** (L24)

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A. Suspension of Admissions: (L44)
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26. TERMINATION ACTION: (L30)

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INVOLUNTARY
05-Fail to Meet Health/Safety
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
November 1, 2021

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: CCN: 245255
Cycle Start Date: October 7, 2021

Dear Administrator:

On October 7, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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 January 7, 2022 (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 April 7, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE SAINT PAUL, MN 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
E 000	Initial Comments A Recertification, Complaint, and Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health on 10/04/21 through 10/07/21. The facility was found not to be in compliance with 42 CFR 483.73.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007		12/7/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/10/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE SAINT PAUL, MN 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
E 007	Continued From page 1 plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility All-Risk Emergency Operations Plan failed to address the resident population including, but not limited to, residents most at-risk; the type of services the facility has the ability to provide in an emergency and continuity of operations that could be provided to those residents most at risk. This had the potential to affect all 82 residents residing in the facility. Findings include: Review of the facility All-Risk Emergency Operations Plan (EOP) dated February 2021 demonstrated the EOP did not specify the resident populations most at risk in the facility. In addition, the plan did not specify how the facility would respond to resident needs for those populations most at risk and the plan did not specify what types of services the facility would be able to provide to those residents in an emergency. Review of facility Shelter in Place policy and Appendix J - Shelter in Place did not address resident most and risk, the type of services the facility has the ability to provide in an emergency and continuity of operations that could be provided to those residents most at risk, During interview on 10/6/21, at 1:00 p.m. administrator stated the facility assessment	E 007	E007 Program Patient Population This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency A statement has been placed in each emergency preparedness binder to determine the following: At risk population Response to resident needs during an emergency Services provided during an emergency Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No areas were identified. The EOP follows the Facility Assessment to determine the resident population that is most at risk. All residents within a Skilled Nursing Facility are considered Vulnerable Adults and At-Risk. Systematic Changes To Ensure Deficiencies Do Not Reoccur A statement has been placed in each emergency preparedness binder to determine the following: At risk population Response to resident needs during an emergency Services provided during an emergency	

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E 007	Continued From page 2 spoke to the specific resident population that existed in the facility and the EOP was general to all residents. Administrator stated the facility assessment did not include services and continuity of operations that could be provided to identified at risk resident populations during and emergency. Review of the Facility Assessment dated October 2021 listed specific resident populations residing in the facility by disease category but did not include continuity of services that could be provided to those resident populations most at risk in the facility during and emergency.	E 007	Ongoing Monitoring Facility will continue to review the EOP annually and review at Quality Assurance Meetings for any changes and approvals. Any issues or trends will be reported to the QA Committee Person Responsible Administrator Completion Date: December 7, 2021	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training.	E 037		12/7/21

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CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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E 037	Continued From page 3 (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

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E 037	Continued From page 4	E 037		

(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

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	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

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E 037	Continued From page 5 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster	E 037		

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E 037	Continued From page 6 authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide required training in emergency preparedness policies and procedures that was specific to the facility and was consistent staff's roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This had the potential to affect all 82 residents residing in the facility. Findings include:	E 037	E037 EP Training Program This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency The facility updated the required training in emergency preparedness policies and procedures to make it specific to the facility and is consistent to staff's roles in an emergency for all new and existing staff, individuals providing services under	

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	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

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E 037	Continued From page 7 Document review revealed the annual emergency preparedness training had been completed using a general on-line module from their learning management system, Educare, entitled Emergency Preparedness - Human Hazards. The learning objectives in this module did not demonstrate training in facility specific emergency preparedness policies and procedures consistent with their expected facility specific roles in an emergency. During interview on 10/7/21, at 11:23 a.m. wellness coach stated during the last year she had taken an Educare module on emergency preparedness and stated it was not specific to the facility and she could not recall any other emergency preparedness education provided by the facility during that time. During interview on 10/7/21, at 11:25 a.m. certified nursing assistant -11 stated during the last year she had taken an Educare module on emergency preparedness and stated it was not specific to the facility and she could not recall any other emergency preparedness education provided by the facility during that time. During interview on 10/6/21, at 1:00 p.m. director of environmental services (DES) stated training is done each year with staff on the fire and severe weather codes and stated this training does not refer to the facility emergency operations plan (EOP) and was not documented. DES stated the documented training was done on the Educare care module and that training was not specific to the facility . During interview on 10/7/21 at 9:33 a.m. staff development director (SDD) stated the	E 037	arrangement, and volunteers. Training refers to the facility emergency operations plan and is documented in the Educare system and with the Staff Development Coordinator. Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were identified upon review. Facility provides education on emergency preparedness during orientation, during drills , and as needed. During new staff orientation, staff are educated on emergency preparedness and a copy of the training is kept in their file. Educare is completed on emergency preparedness. When drills are completed, the drill is discussed and reviewed with employees and in-service sheets are signed. Systematic Changes To Ensure Deficiencies Do Not Reoccur All staff upon orientation are educated on site specific policies and procedures and expectations during an emergency. Employee will sign the education sheet and it will be placed within their file. Staff will sign in-service sheets during disaster drills to ensure awareness of procedures during a disaster. Ongoing Monitoring Drills will continue per schedule and regulations. Orientation sheets will be signed by employees on site specific emergency preparedness training and monitored	

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E 037	Continued From page 8 documented annual education on emergency preparedness that includes demonstration of knowledge has been the Educare module. SDD stated the Educare module is not specific to the facility EOP and does not address staff's role in the facility during an emergency. Emergency Operations Plan, dated February 2021, stated " Education and training, including drill and exercises, are utilized in this community to achieve proficiency during emergency response. In compliance with state and federal regulations, our community conducts initial training on the EOP during the orientation of new associates, and annually to all associates or as needed if the EOP is changed.	E 037	monthly for 3 months by Staff Development Ongoing education will be completed as needed and monitored monthly for 3 months by Staff Development Any issues or trends will be reported to the QA Committee Person Responsible Staff Development Human Resources Director of Nursing Director of Environmental Service Administrator Completion Date: December 7, 2021	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location	E 041		12/7/21

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E 041	Continued From page 9 requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call	E 041		

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E 041	Continued From page 10 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the generator per 2012 edition of the Life Safety Code NFPA 101 section 9.1.3.1 and NFPA 99 (2012 edition), Health Care Facilities Code,	E 041	E041 Hospital CAH and LTC Emergency Power This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt.	

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E 041	Continued From page 11 sections 6.4.4.1.1.4, and NFPA 110 the Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2.1. This deficient practice could affect the safety of all 82 residents as well as staff, and visitors to the facility. Findings include: During inspection of the facility generator by the state fire marshal on 10/6/21, at 9:30 a.m., it was revealed by review of available documentation the required monthly generator inspection documentation was not available at the time of the survey. This deficient practice was confirmed by the director of environmental services (DES). During interview on 10/7/21, at 10:56 a.m. DES stated "I wasn't documenting the full monthly test. I was only documenting the load percentage and a lot more than that is required to be documented."	E 041	Corrective Action for Areas Identified in Deficiency The facility received the updated generator form per the 2012 edition of the Life Safety Code NFPA 101 section 9.1.3.1 and NFPA 99 Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were identified Systematic Changes To Ensure Deficiencies Do Not Reoccur During all generator testing the correct NFPA forms will be used according to guidelines and kept in a binder Ongoing Monitoring Only the most updated forms will be used per NFPA guides Any issues or concerns related to the generator and testing will be reported to the QA Committee Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
F 000	INITIAL COMMENTS On 10/4/21 to 10/7/21, a standard recertification survey was conducted at your facility by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health . A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 12 The following complaints were found to be SUBSTANTIATED however NO deficiencies were cited due to actions implemented by the facility prior to survey. H5255101C (MN70161). The following complaints were found to be UNSUBSTANTIATED: H5255102C (MN65302), H5255103C (MN60795), H5255104C (MN59656), H5255105C (MN58915), H5255106C (MN58367), H5255107C (MN52459), H5255108C (MN58317), H5255109C (MN56399), and H5255110C (MN56030). 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.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with	F 576		12/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 576	Continued From page 13 individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all 82 residents residing at the facility. Findings include: Review of the facility's resident "Hospitality Guide," dated 2020, revealed " ...Postal Service.	F 576	F576 Right To Forms of Communication with Privacy This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency Residents received all mail same day as delivered Monday thru Saturday.	

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F 576	Continued From page 14 Your mail is delivered unopened, Monday through Saturday ..." During the Resident Council Group interview on 10/05/21, at 10:30 a.m. the group stated the facility did not deliver mail to residents on Saturdays. Interview on 10/06/21, at 11:20 a.m. with the Wellness Director revealed the business office receives the mail and then either herself or the wellness coaches deliver the mail to the residents. The Wellness Director stated right now, she did not have a staff member to deliver mail on Saturdays; however, she was in the process of hiring wellness coaches for the weekend and mail would be delivered again on Saturdays once that happened. Interview on 10/07/21, at 4:13 p.m. with the administrator revealed it was her expectation that mail would be sorted and delivered to residents each day it was delivered to the building by the mailman.	F 576	Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were identified. All residents received mail. Systematic Changes To Ensure Deficiencies Do Not Reoccur A spreadsheet of all residents was created to determine who is to receive their own mail. This will be updated as changes occur. Charge of Building or Designee will be responsible for sorting and delivering mail on Saturdays when no Wellness staff are available to sort and deliver mail. Ongoing Monitoring During monthly Resident Council meetings, residents will be asked if they are receiving mail on Saturdays. Administrator will follow up on Monday mornings to ensure mail was delivered timely on Saturdays, weekly until compliance is sustained. Any issues or trends will be reported to the QA Committee Person Responsible Administrator Wellness Director or Designee Completion Date: December 7, 2021	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		12/7/21

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F 623	Continued From page 15	F 623		

resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE SAINT PAUL, MN 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
F 623	Continued From page 16	F 623		

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

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F 623 Continued From page 17 F 623

as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure residents and their representatives were notified in writing of transfers for two of two residents (R71 and R26) reviewed for hospital transfers out of a sample of 31 residents.

Findings include:

Review of the facility's undated policy titled, "Bed Hold," revealed "Purpose: To inform residents and their responsible parties of rights regarding bed holds during hospitalizations and therapeutic leaves and prevent fraud, waste, and abuse and ensure proper reimbursement ...2. This policy requires that two notices be issued: The first notice, which explains and provides written information regarding the Facility's bed hold policy, should be provided upon admission. Re-issuance of the first notice is required if the bed hold policy under the State plan or the Facility's policy were to change ...The second notice, which specifies the duration of the bed hold policy, must be issued at the time of hospital

F623 Notice Requirements Before Transfer/Discharge
This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt.
Corrective Action for Areas Identified in Deficiency
R71 and R26 representatives were verbally notified and were provided notification of transfer in writing after the time of transfer.

Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action
Residents who were not provided a written notice of transfer in the past 30 days were provided a written notice of transfer.
Systematic Changes To Ensure Deficiencies Do Not Reoccur
Administrative Assistant or Designee will review all transfers and discharges daily Monday thru Friday. A written letter of

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	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 18 transfer or therapeutic leave ...3. For emergency hospital transfers, the resident, responsible party, or legal representative is provided with written notification within 24 hours of the transfer ..." 1. Review of R71's undated "Resident Face Sheet," located in the resident's electronic medical record (EMR) under the face sheet tab, revealed the resident was admitted to the facility on 07/20/21, and readmitted on 09/09/21, with diagnoses which included fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing. Review of R71's "Notice of Voluntary Resident/Patient Transfer or Discharge," dated 09/01/21, provided by the facility, revealed R71 was transferred to the hospital on 09/01/21, for the resident's welfare and the resident's needs could not be met in the facility. The form was given to the resident; however, there was no documented evidence the written notice was also sent to the resident's representative. Review of R71's "Resident Progress Notes," dated 09/01/21, located in the resident's EMR under the "Progress Notes" tab revealed "Patient not feeling well this morning, complaining of a cough, sinus congestion, malaise, nausea, and emesis ...Patient sent to [name of hospital] via ambulance ..." 2. Review of R26's undated "Resident Face Sheet," located in the residents' EMR under the "Face Sheet" tab, revealed the resident was admitted to the facility on 07/21/21, with diagnoses which included dementia. Review of R26's "Notice of Voluntary Resident/Patient Transfer or Discharge," dated	F 623	transfer/discharge will be mailed certified to the Responsible Party. The green card for certified mail will be copied and uploaded into the residents EMR as evidence of the transfer form being sent. Administrative Assistant and BOM were in-serviced on the new protocol for notifying resident responsible parties of the transfer/discharge notice. Nurses are responsible for verbally notifying the resident representative upon transfer and sending notification with resident upon transfer. Ongoing Monitoring Business Office Manager or Designee will review weekly x 4 for 3 months for accuracy and completion of transfer notices being sent until compliance is sustained. Results will be forwarded to QA Committee for any necessary modifications or re-education or continued monitoring. Any issues or trends will be reported to QA Committee Person Responsible Business Office Manager Completion Date: December 7, 2021	

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	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 623	Continued From page 19 09/06/21, provided by the facility, revealed R26 was transferred to the hospital on 09/06/21, for the resident's welfare and the resident's needs could not be met in the facility. The form was given to the resident; however, there was no documented evidence the written notice was also sent to the resident's representative. Review of R26's "Resident Progress Notes," dated 09/06/21, located in the resident's EMR under the "Progress Notes" tab revealed the resident was sent to the emergency room due to persistent coughing. Interview on 10/06/21, at 9:14 a.m. with family member (F) 1, who was the resident's representative, revealed she was notified by telephone of the resident's transfer to the hospital; however, she did not receive any type of notification in writing from the facility. Interview on 10/06/21, at 10:00 a.m. with the social service director (SSD) revealed when a resident was sent to the hospital, a written notice transfer form was sent with the resident; however, the facility did not mail out any written notice to any responsible parties. Interview on 10/07/21, at 4:08 p.m. with the Interim Director of Nursing (IDON) revealed she was not aware of the regulatory requirement to send representatives written notification of resident transfers to the hospital. Interview on 10/07/21, at 4:13 p.m. with the administrator revealed she was aware that the representative needed to be contacted verbally of resident transfers; however, she was not aware that written notification needed to be sent to representatives.	F 623		

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F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to assess a resident's pain level prior to and after administration of pain medication. The facility further failed to evaluate the effectiveness of regularly scheduled pain medication. This affected 1 of 2 residents (R71) reviewed for pain management. Findings include: Review of the facility's policy titled, Assessment and Management of Pain, reviewed 05/22/07, revealed ...Policy. To ensure the resident is either pain free or pain will be at a level that the patient judges as acceptable ...To effectively screen an assess each resident's pain using a systematic approach using a comprehensive assessment tool ...Procedure...5. Assess pain using the Pain Rating Scale of 0-10 ...11. Evaluate and document outcomes of interventions ... Review of R71's undated Resident Face Sheet, located in the resident's electronic medical record (EMR) under the face sheet tab, revealed the resident was admitted to the facility on 07/20/21, and readmitted on 09/09/21, with diagnoses which included fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing.	F 697	F697 Pain Management This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency R71 MAR was updated to include evaluation before and after administration of scheduled and PRN medications. R71 care plan was updated to reflect changes. Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action Audit was completed for all residents receiving both PRN and scheduled pain medications. All residents receiving schedule and PRN pain medication had orders were entered with tasks, which remain open until they are completed. These tasks include the reason for the pain medication, pain level before administration, pain level after administration, and the result of effectiveness. Care plans were updated as needed to reflect any changes. Systematic Changes To Ensure Deficiencies Do Not Reoccur	12/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

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F 697	Continued From page 21 Review of R71's significant change in status Minimum Data Set (MDS), with an assessment reference date (ARD) of 08/22/21, located in the resident's EMR under the RAI (resident assessment instrument) tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Continued review of the MDS revealed the resident was assessed to be on a pain management regimen and experienced moderate level of pain with the frequency of occasionally. Review of R71's Medication Administration Record (MAR), dated 10/01/21-10/06/21, revealed the resident was ordered Tramadol (a medication used to treat pain) 25 milligram (mg) four times a day for chronic pain. Continued review of the MAR revealed the resident had been administered the pain medication everyday as ordered. Further review of the MAR revealed the sections of the MAR was not completed for the resident's pain level from 0-10 before or after the administration of the pain medication. Licensed practical nurse (LPN) 7 had administered R71 14 out of 22 doses and did not assess the resident's pain pre or post administration. Interview on 10/06/21, at 12:18 p.m. with R71 revealed her physician had recently cut her Tramadol pain medication from 50 mg, four times a day to 25 mg, four times a day and she was starting to have increased pain. Continued interview with R71 revealed the nursing staff did not ever ask her pain levels before or after administration of the pain medication.	F 697	Nurses and TMA's were in-serviced on the protocol to follow for pain medication administration. Training will be ongoing for any new staff members. A review of the protocol will be reviewed as needed. Unit managers will review new admissions and new orders for pain medication for pre and post med administration pain evaluation. Ongoing Monitoring Clinical Managers will review and audit 5 random residents on a weekly basis for 3 months for accuracy and completion of tasks in the pain medication administration orders. Any discrepancies will be provided to the Director of Nursing for proper follow up. Any issues or trends will be reported to the QA Committee Person Responsible Director of Nursing Clinical Managers Completion Date: December 7, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

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F 697	Continued From page 22 Interview on 10/06/21, at 12:33 p.m. with LPN7 revealed R71 received 25 mg of Tramadol, scheduled four times a day for pain. LPN7 stated since R71 always complained of pain, he did not ever ask her to rate her pain level. When asked if he ever ask the resident about the effectiveness of the pain medication, LPN7 stated he was usually really busy and did not always go back and asked the resident if the medication worked. Interview on 10/06/21, at 12:39 p.m. with Unit Manager (UM) 3, confirmed if R71 was not offering the information about her pain level or the effectiveness, and the nurse was not asking, then there would be no way of knowing if the pain medication was effective. UM3 stated it was her expectation that the nurse would have asked R71 her pain level before administering pain medication and then follow up afterward for effectiveness. Follow up interview on 10/06/21, at 2:15 p.m. with LPN7 revealed when asked about him documenting that the pain medication was effective, LPN7 stated that meant at sometime during his shift, he went back into the R71's room and asked the resident how she was doing, and she would say "ok," which meant her medications were effective. LPN7 confirmed he did not ever ask R71 to rate her pain level.	F 697		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		12/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

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F 761	Continued From page 23 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to remove expired stock medications and medical supplies from three of three medication rooms located on the second, third, and fourth floors. This had the potential to affect any resident who might be prescribed the medications or the need for the medical supplies that had expired. Findings include: Observation of the facility's medication rooms on 10/06/21 at 11:00 a.m. revealed the following: 1. Observation of the second-floor medication room revealed six boxes of albuterol sulfate inhalant with expired dates ranging from 07/21	F 761	F761 Label/Storage Drugs and Biologicals This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency All expired medication and supplies were removed from all three medication rooms and destroyed appropriately. Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action All expired medication and supplies were removed from all three medication rooms and destroyed appropriately.	

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	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

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F 761	Continued From page 24 and 08/21. One box of ipratropium bromide inhalant had an expiration date of 08/21. The boxes were stock medications and not prescribed to a specific resident. An interview with licensed practical nurse (LPN) 8 during the observation confirmed the expired medications in the second-floor medication room. She revealed she was not sure what the facility's practice was for checking the medication room. LPN8 stated she tried to check the medication room monthly to ensure there were no expired drugs, however had not checked the room recently for expired medication or supplies. 2. Observation of the fourth-floor medication room on 10/06/21, at 3:55 p.m. revealed four boxes of telfa dressing pads with an expiration date of 12/2020, 69 packets of Nutrisource fiber (nutritional supplement) with expiration date of 12/2020. An interview with registered nurse (RN) 4 during the observation confirmed the expired items. RN4 stated he was unsure who was responsible for checking the medication room for expired medications and supplies. 3. Observation of the third-floor medication room on 10/06/21, at 4:20 p.m. with RN5 revealed one box convac techaquagel (dressing) with expiration date 05/01/21, and 16 vacutainer tubes (for blood draws) with expiration date 03/13/21. Interview with RN5 during the observation confirmed the expired medical supplies and she was not sure of the process for checking medications/medical supplies for expiration dates. Interview with the second floor Unit Manager (UM)2 on 10/07/21, at 9:15 a.m. revealed the	F 761	No other areas store medications or supplies Systematic Changes To Ensure Deficiencies Do Not Reoccur All nurses and TMA's are required to check each shift for any expired medications and supplies in their respective medication and treatment carts. If any expired medications or supplies are found they are to place them in the medication room with a note of expiration date. At discharge, if medications are not sent with the patient, the meds are to be put in a bag with the patient name and discharge date and placed in the medication room for the Clinical Managers to dispose of properly. Clinical Managers are responsible for checking the medication rooms weekly for any expired medications or supplies. The removal will be done according to regulations. Nurses and TMA's and Clinical Managers were in-serviced to the protocol and procedure for expired medications and supplies. Ongoing Monitoring Clinical Managers will check the med rooms weekly for expired medications or supplies and destroy according to regulations. Discrepancies will have follow up and or necessary re-education. Any issues or trends will be reported to the QA Committee Person Responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 25 nurses were responsible for checking for expired medications/supplies. On 10/07/21, at 3:43 PM an interview with the interim director of nursing (IDON) revealed the unit managers had made her aware of the expired medications and supplies found in the medication rooms. The IDON stated the nurses were responsible for checking the medication rooms for expired drugs. The IDON confirmed the facility did not have a policy or written procedure in place for disposing of expired medications and medical supplies.	F 761	Director of Nursing Clinical Managers Completion Date: December 7, 2021	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 812	F812 Food Procurement,	12/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 26 review, the facility failed to ensure the kitchen in the nursing home (NH) and assisted living (AL) were maintained to ensure a sanitary environment. The facility further failed to document temperatures of the freezers and refrigerators. This had the potential to affect 79 of the 82 residents in the facility. Findings include: Interview with the Culinary Director (CD) on 10/05/21, at 1:30 p.m. revealed she was responsible for the kitchen of the NH and AL, which were located in the same building. Currently the meals for the nursing home were prepared in the assisted living facility's kitchen then transferred in heated carts to the nursing home kitchen. The food trays were then placed in the NH steam wells to maintain required temperatures. The staff in the NH plates the food for residents and it is sent to the residents on the floors in the NH. 1. Observation of the AL kitchen on 10/06/21, at 8:45 a.m. identified the following concerns: The kitchen cooler/freezer had a document on the door titled "Kitchen Cooler/Freezer Log" (undated). Day 1 revealed the walk-in cooler had a temperature recorded of 39.6 degrees Fahrenheit (F). There were no other recorded temperatures documented. A cooler labeled for new lunch items only had the same document with no temperatures recorded after day 1. The refrigerator had container with eight hot dogs with no date; one large container of tartar sauce;	F 812	Store/Prepare/Serve-Sanitary This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency All containers in the refrigerator were dated. The freezers and coolers were cleaned and food items were stored in a sanitary manner Temperatures of the freezers and coolers were documented. Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action All kitchen refrigerators and freezers will have temperature logs completed daily All open items or containers will be dated with the date opened. All freezers and coolers were checked and items were stored in a sanitary manner Systematic Changes To Ensure Deficiencies Do Not Reoccur In-service of culinary employees on temperature requirements of the refrigerators and freezers, as well as the requirement to check the temperatures daily and record on the temperature log. In-service of culinary employees on dating any opened packages or containers of food/drink in the coolers or freezers. In-service of culinary employees on the cleaning of floors and shelves in the coolers and freezers. In-service of culinary employees on the	

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	245255	A. BUILDING ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 27 one large jar of yellow mustard; one jar of apricot jelly all opened and no date. The room that housed the walk-in freezer, walk-in refrigerator, another silver freezer, and silver refrigerator revealed the silver freezer was missing temperatures for 10/02/21, 10/03/21, and 10/05/21. The bottom shelf of the freezer had a red color sticky substance next to a bag of frozen chicken. The walk-in freezer had a temperature reading of nine degrees (F). There were no temperatures recorded since 10/01/21. The walk-in cooler had a temperature reading of 39 degrees (F) and there were no temperatures recorded since 10/01/21. The floor of the walk-in cooler had red color drainage on the plastic covering on two meats on the fourth shelf. The red color drainage dripped onto two boxes of boneless pork on the fifth shelf and then dripped onto the floor of the cooler. Interview with the CD on 10/06/21, at 12:15 p.m. confirmed there was a problem with the staff recording the temperatures of the refrigerators and freezers in both facility kitchens in a consistent manner. The CD confirmed the identified observations of the cleanliness of the AL kitchen and was in the process correcting the concerns.	F 812	sanitary storage of food items in the coolers and freezers, including how to appropriately thaw food items in a sanitary manner. Ongoing Monitoring Culinary Director or Designee will audit the cooler and freezer temp logs daily to ensure completion for 3 months. Culinary Director or Designee will audit open containers of food daily in the coolers/freezers for items dated accordingly for 3 months. Culinary Director or Designee will audit for storage of items in a sanitary manner daily for 3 months Any trends or issues will be reported to the QA Committee Person Responsible Culinary Director or Designee Completion Date: December 7, 2021	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		12/7/21

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F 921	Continued From page 28 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure two of three residents (R) R19 and R47 who receive enteral feedings had clean equipment as well as the floor around the intravenous (IV) pole of the pumps, in addition, the facility failed to ensure fans being used in the kitchen were free from dirt and debris. This had the potential to affect 79 of the 82 residents in the facility. Findings include: 1. Observation on 10/04/21, at 9:30 a.m. revealed R19 was in bed with a tube feeding infusing via feeding pump with dried beige color splatter on IV pole, pump, and on the floor beside the bed. Additional observation on 10/05/21, 8:51 a.m. revealed the resident had a tube feeding infusing via feeding pump with dried beige color splatter on the pump, IV pole, and on the floor. 2. Observation on 10/04/21, at 12:20 p.m. revealed R47 was in a reclining wheelchair in the day room with a tube feeding infusing via a feeding pump. The feeding pump and IV pole had dried beige color splatter. Additional observation on 10/05/21, at 9:57 a.m. in R47's room revealed the resident was in lying in bed with a tube feeding infusing via a feeding pump. The IV pole, pump, and floor were observed with dried beige color spatter. During an interview on 10/06/21, 1:24 p.m. with licensed practical nurse (LPN) 8 confirmed there was dried beige color splatter on the pump, IV pole, and floor in R19's room, as well as R47's	F 921	F921 Safe/Functional/Sanitary/Comfortable Environment This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency R19 had an IV pole that was changed out with a brand new pole for feeding. R47 had an IV pole that was changed out with a brand new pole for feeding. Floors for R19 and R47 were cleaned All fans in the kitchen were cleaned Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action All tube feeding and IV poles were cleaned All fans were cleaned in the kitchen Floors are cleaned daily and as needed if soiling occurs Systematic Changes To Ensure Deficiencies Do Not Reoccur Clinical Staff were educated to check cleanliness of all IV/tube feeding poles prior to use and when visibly soiled. Clinical staff will check cleanliness of floors surrounding poles for cleanliness Culinary staff were in-serviced on checking fans prior to use to ensure they are clean and free of debris or dust on the grill and blades. Staff were educated to not direct fans	

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F 921	Continued From page 29 room. LPN 8 also stated the feeding pump, and IV poles should be cleaned by the nursing staff as needed. Housekeeping was responsible for cleaning the floor area around the IV pole. Interview with the interim director of nursing (IDON) on 10/07/21, at 4:00 p.m. revealed that she had been informed about the concerns regarding the spilled formula on feeding pumps and IV pole. Currently the facility did not have a policy regarding the care and cleaning of the feeding pumps and IV poles. 3. On 10/06/21, at 8:25 a.m. observation in NH kitchen revealed the breakfast meal service was in progress. Three staff members were preparing meal trays. There was fan positioned on a cart facing the area where staff members were preparing the food. The fan had dust debris on the grill and blades. The fan remained in this position throughout the entire meal service. An additional observation of the lunch meal in the NH on 10/06/21, at 11:35 a.m. revealed the same dirty fan observed during the breakfast meal at 8:25 a.m. was now positioned facing the area where the drinks were being prepared. The dietary aide prepared 28 cups of coffee and tea on a cart which was facing the dirty fan and blowing on the drinks. The cups were left uncovered for a period five minutes. An additional observation noted a second fan placed on a cart facing an area where another dietary aide was preparing the trays with silverware napkins for lunch service. 4. On 10/06/21, at 8:45 a.m. observation of the AL kitchen revealed a black floor fan positioned towards the area where dishes coming out of the	F 921	towards uncovered food or drinks or clean dishes/pans. Fans will be put on a regular cleaning schedule Ongoing Monitoring Clinical managers will audit IV poles and floors 1 x weekly for 3 months or until compliance is substantiated. An audit of the cleanliness of fans as well as sanitary use of fans being used in the kitchen will be completed daily for 3 months or until compliance is achieved and sustained Any issues or trends will be reported to the QA Committee Person Responsible Director of Nursing or Designee Culinary Director or Designee Completion Date: December 7, 2021	

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F 921	Continued From page 30 dish machine were drying (four large pans and two covering tops) The fan had dust debris covering the grill and blades of the fan, it was blowing on the clean dishes. During an interview with the CD on 10/06/21, at 12:15 p.m. during the lunch service in the NH kitchen she confirmed the position of the fans blowing over the drink cart and the tray preparation area in the NH, as well as the dirty fan blowing on the clean dishes in the AL. The CD confirmed the fans had dust debris on the grill and blades and the fans should be cleaned periodically by the kitchen staff. She confirmed the fans should have been placed better to avoid contaminating the food and dishes.	F 921		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cerenity Care on Humboldt 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/10/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Cerenity Care on Humboldt is a 4-story building. 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 was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/06/2021**

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K 000	Continued From page 2 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. The facility has a capacity of 117 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:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of the available documentation, and staff interview, the facility failed to test and maintain the emergency lighting system per NFPA 101 (2012 edition), Life Safety Code, section 7.9.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power, section 7.3.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 10/06/2021 at 11:30 AM, it was revealed by observation that the battery-operated emergency lighting located near the generator did not function when tested.	K 291	K291 Emergency Lighting This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency Battery was replaced on emergency lighting near the generator Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas of battery operated lighting were identified within the facility. Systematic Changes To Ensure Deficiencies Do Not Reoccur Facility will do an audit every 2 weeks for 3 months to ensure the battery operated	12/7/21

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K 291	Continued From page 3 2) On 10/06/2021 at 11:30 AM, it was revealed by the review of available documentation that the testing records of battery-operated emergency lighting were not available at the time of the survey. An interview with the Director of Environmental Services (CL) verified these deficient findings at the time of discovery. .	K 291	lighting is in working order. Ongoing Monitoring Facility will conduct monthly checks to ensure battery is functioning properly. Any trends will be reported to QA. Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		12/7/21

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K 321	Continued From page 4 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain several hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 10/06/2021 at 10:30 AM, it was revealed by observation room 123 had combustible storage and did not have a self-closer. 2) On 10/06/2021 at 10:45 AM, it was revealed by the observation in the dry kitchen storage area, room 107C had a kick-down device and did not have a self closure. 3) On 10/06/2021 at 10:40 AM, observation revealed that rooms 124 and 128 contained hazardous storage and did not have a self-closer. In the dry kitchen storage area, room 107C had a kick-down device and did not have a self-closer. 4) On 10/06/2021 at 11:00 AM, it was revealed by the observation that the 2nd-floor utility room did not positively latch when tested. An interview with the Director of Environmental Services (CL) verified these deficient findings at the time of discovery.	K 321	K321 Hazardous Areas-Enclosure This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency Room 123 had a self closer installed Room 107C had a self closer installed Rooms 124 and 128 had a self closer installed The 2nd floor utility room was fixed to positively latch when the door is closed Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were identified without a self closer device. No other areas were identified to not positively latch when closed. Systematic Changes To Ensure Deficiencies Do Not Reoccur Facility purchased extra door closers in the event another door needs a new closer during rounds. Facility will monitor for any doors that do not latch properly and have proper self closers during rounds Ongoing Monitoring Facility will monitor monthly for all	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 5	K 321	appropriate doors to latch properly and have working self closers Any issues or trends will be reported in morning meeting and to the QA Committee. Person Responsible Director of Environmental Service or Designee Completion Date: December 7, 2021	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system as per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/06/2021 at 9:30 AM, it was revealed by a	K 345	K345 Fire Alarm System-Testing and Maintenance This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency All paperwork was emailed to the Fire Marshall to provide proof the fire alarm systems were being tested annually Identifying Other Areas with Potential To Affect Residents and Associated	12/7/21

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K 345	Continued From page 6 review of available documentation that the annual and semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with the Director of Environmental Services (CL) verified these deficient findings at the time of discovery.	K 345	Corrective Action No other areas were identified Systematic Changes To Ensure Deficiencies Do Not Reoccur Facility will maintain a binder with all records for easy access Ongoing Monitoring Facility will continue to conduct fire alarm testing annually and semi-annually per regulations and keep a maintained binder of reports for easy access. Any trends or issues will be reported to the QA Committee Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		12/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE** **SAINT PAUL, MN 55107**

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K 353	Continued From page 7 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/06/2021 at 10:35 AM, it was revealed by observation that the abandoned walk-in cooler had a corroded sprinkler head in it. An interview with the Director of Environmental Services (CL) verified this deficient finding at the time of discovery.	K 353	K353 Sprinkler System-Maintenance and Testing This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency The facility contacted the vendor to replace the corroded sprinkler head. Fire Marshall was emailed all records provided by the vendor to ensure completion of testing and maintenance of sprinkler system Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action Upon review within the facility, no other sprinkler heads were noted to be corroded. Systematic Changes To Ensure Deficiencies Do Not Reoccur Corroded sprinkler head was replaced on October 29, 2021. Facility will audit sprinkler heads for corrosion and have any corroded sprinkler heads replaced in a timely fashion Ongoing Monitoring Facility will conduct checks monthly to determine if any sprinkler heads are corroded and need to be replaced. Any trends or concerns will be reported to QA Committee Person Responsible	

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<tr><td>K 353</td><td>Continued From page 8</td><td>K 353</td><td>Director of Environmental Service

Completion Date: December 7, 2021</td><td></td></tr>
<tr><td>K 511
SS=D</td><td>Utilities - Gas and Electric
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 REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain the exhaust ducting on a fuel-fired appliance per NFPA 101 (2012 edition), Life Safety Code, section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, section 10.4.5.4. This deficient finding could have an isolated impact on the residents within the facility.

Findings include:

On 10/06/2021 at 11:45 AM, it was revealed by observation that behind 2 of the three commercial dryers, the exhaust duct had 2-inch holes that were not sealed.

An interview with the Director of Environmental Services (CL) verified this deficient finding at the</td><td>K 511</td><td>K511 Utilities-Gas and Electric
This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt.
Corrective Action for Areas Identified in Deficiency
Facility fixed the holes with fire rated covers

Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action
No other of fueled fired appliances were noted to have holes in the ducts.
Systematic Changes To Ensure Deficiencies Do Not Reoccur
Facility repaired the holes in the exhaust</td><td>12/7/21</td></tr>
</table>

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K 511	Continued From page 9 time of discovery.	K 511	ducts with fire rated covers. In-service to laundry staff to check for any issues during laundry care and to inform Director of EVS immediately with any issues noted. Ongoing Monitoring Facility will monitor exhaust ducts for any further holes and repair accordingly monthly or until compliance is substantiated Any trends or issues will be reported to QA Committee Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the heating, ventilation, and air conditioning system in per NFPA 101 (2012 edition), Life Safety Code, sections 9.2, 19.5.2.1, and NFPA 80	K 521	K521 HVAC This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in	12/7/21

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K 521	Continued From page 10 Standard for Fire Doors and Other Opening Protective's (2010 Edition), Sections 19.4.9, 19.4.10 and 19.5.5 and NFPA 105 Standard for Smoke Door Assemblies and Other Opening Protective's (2010 Edition), Sections 6.5.11, 6.5.12 and 6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/06/2021 at 08:30 AM, it was revealed by a review of available documentation that the facility had exceeded the required four-year testing of the smoke and fire dampers. An interview with the Director of Environmental Services (CL) verified this deficient finding at the time of discovery.	K 521	Deficiency Facility emailed Fire Marshall all current documentation to ensure facility was completing the damper testing every 4 years. Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were noted during review of systems. Systematic Changes To Ensure Deficiencies Do Not Reoccur All paperwork will be kept in a binder for easy access once received from the 3rd party vendor Ongoing Monitoring Facility will continue to have 3rd party vendor complete the testing of the smoke and fire dampers every 4 years. Any issues or concerns will be brought to the QA committee. Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		12/7/21

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K 712	Continued From page 11 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4 through 19.7.1.7, and section 9.6.1.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/06/2021 at 8:15 AM, it was revealed by a review of available documentation that the fire drill reports did not document the integrity of the alarm transmission during the last 12 months for the night shift. An interview with the Director of Environmental Services (CL) verified this deficient finding at the time of discovery.	K 712	K712 Fire Drills This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency Facility conducted silent drills on the night shift and contacted the vendor to ensure the fire alarm was in working condition Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were identified. Systematic Changes To Ensure Deficiencies Do Not Reoccur Paperwork and forms will be completed and kept in a fire drills binder to ensure night shift drills are being conducted properly and the vendor is contacted the following day to ensure the alarm is in working order. Ongoing Monitoring All night shift drills will occur according to the fire drill schedule. Facility will check the alarm after night shift drills when residents are not sleeping. All paperwork will be kept in a binder for easy access. Any trends or issues will be reported to	

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K 712	Continued From page 12	K 712	QA Committee Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to conduct inspections of all fire-rated doors per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.15.2 and 7.2.1.15.4, and NFPA 80 (2010 edition), sections 5.2.4.2 and 4.8.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 761	K761 Maintenance, Inspection & Testing-Doors This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency All doors were reviewed to ensure doors did not have more than a ¾ inch gap when measured with a gap tool	12/7/21

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K 761	Continued From page 13 1) On 10/06/2021 at 9:30 AM, it was revealed by a review of available documentation that the annual fire-rated door inspection was not conducted, and documentation was not available at the time of the survey. 2) On 10/06/2021 at 11:30 AM, it was revealed by observation the fire-rated door on the second floor to the skyway had more than a 3/4 inch gap at the bottom when measured with the door gap tool. An interview with the Director of Environmental Services (CL) verified these deficient findings at the time of discovery.	K 761	Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were noticed upon walk thru of the facility Systematic Changes To Ensure Deficiencies Do Not Reoccur The 13 point check was completed on 11/3/21. The gap larger than ¾ in has been adjusted by installing a sweeper to the bottom of the door. Ongoing Monitoring The yearly 13 point check will be completed appropriately to ensure there are no fire doors with less than a ¾ inch gap Any trends or issues will be reported to the QA Committee Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		12/7/21

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K 901	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to validate that the building systems were designed to meet Category 1 through 4 requirements as detailed in NFPA 99 (2012 Edition), Health Care Facilities Code, Chapter 4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/06/2021 at 09:30 AM, it was revealed by a review of available documentation that the fundemental risk assessment was not available at the time of the survey. An interview with the Director of Environmental Services (CL) verified this deficient finding at the time of discovery.	K 901	K901 Fundamentals-Building System Categories This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency The facility reviewed and completed the form to ensure that the building systems were designed to meet Category 1 through Category 4 requirements as detailed in NFPA 99. Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were noted during review Systematic Changes To Ensure Deficiencies Do Not Reoccur The correct form will be used going forward to ensure the building systems are designed to meet Category 1 thru 4. Ongoing Monitoring Forms will be completed according to regulation annually and kept in a binder Any trends or issues will be reported to the QA Committee Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
K 914 SS=F	Electrical Systems - Maintenance and Testing	K 914		12/7/21

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K 914	Continued From page 15 CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test electrical receptacles at patient bed locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.3.2 and 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/06/2021 at 9:30 AM, it was revealed by a review of available documentation that the annual receptacle inspection documentation was not	K 914	K914 Electrical Systems-Maintenance and Testing This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency Updated form was provided by the Fire Marshall and inspections were started to ensure electrical receptacles are in working order Identifying Other Areas with Potential To Affect Residents and Associated	

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K 914	Continued From page 16 available at the time of the survey. An interview with the Director of Environmental Services (CL) verified this deficient finding at the time of discovery.	K 914	Corrective Action No other areas were identified. Systematic Changes To Ensure Deficiencies Do Not Reoccur Inspections to be conducted as per guidelines. Inspections began on November 1, 2021 and will be ongoing until building is completed. Ongoing Monitoring All inspections will be completed on the appropriate forms annually and as needed Any issues or concerns will be reported to QA Committee Person Responsible Director of Environmental Service Completion Date: December 7, 2021	
K 918 SS=F	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 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	K 918		12/7/21

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K 918	Continued From page 17 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the generator per NFPA 101 (2012 edition), Life Safety Code, section 7.9.2.2, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4..1 and 8.4.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/06/2021 at 9:30 AM, it was revealed by a review of available documentation that there was no evidence provided to verify the completion of a monthly generator run test.	K 918	K918 Electrical Systems-Essential Electrical Systems This Plan of Correction does not constitute admission of a deficiency within Cerenity Senior Care Humboldt. Corrective Action for Areas Identified in Deficiency The facility received the updated form per NFPA guidelines Identifying Other Areas with Potential To Affect Residents and Associated Corrective Action No other areas were identified Systematic Changes To Ensure Deficiencies Do Not Reoccur During all generator testing the correct NFPA forms will be used according to guidelines	

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K 918	Continued From page 18 An interview with the Director of Environmental Services (CL) verified this deficient finding at the time of discovery.	K 918	All completed forms will be kept in a binder to ensure completion and availability of documentation Ongoing Monitoring Only the most updated forms will be used per NFPA guides Any issues or concerns related to the generator and testing will be reported to the QA Committee Person Responsible Director of Environmental Service Completion Date: December 7, 2021	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 1, 2021

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

Re: State Nursing Home Licensing Orders
Event ID: 1PS411

Dear Administrator:

The above facility was surveyed on October 4, 2021 through October 7, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility’s Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00538	A. BUILDING: ____ B. WING ____	C **10/07/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE SAINT PAUL, MN 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) COMPLETE DATE
2 000	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 10/4/21 to 10/7/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000	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.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/10/21

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5255101C (MN70161). The following complaints were found to be UNSUBSTANTIATED: H5255102C (MN65302), H5255103C (MN60795), H5255104C (MN59656), H5255105C (MN58915), H5255106C (MN58367), H5255107C (MN52459), H5255108C (MN58317), H5255109C (MN56399), and H5255110C (MN56030).	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426		11/10/21

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CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE SAINT PAUL, MN 55107**

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21426	Continued From page 2 This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) (a serious disease that mostly affects the lungs and in which there is fever, cough, and difficulty in breathing) risk assessment was completed. In addition, facility failed to complete a required tuberculin skin test (TST) for 1 of 6 residents (R27) reviewed and failed document completion of a TB screening tool prior to administering a TST and failed to provide documentation of a TST for 6 of 9 employees reviewed for TB testing. This had the potential to affect all 89 residents in the facility, staff and volunteers. Findings include: During interview on 10/6/21, at 1:32 p.m. infection preventionist (IP) stated she was unable to locate documentation of a facility TB risk assessment that was done during the last year and that there was no documentation of a facility TB risk assessment being done prior to that which could be located.	21426	Corrected	

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21426	Continued From page 3 R27's quarterly minimum data set (MDS) indicated R27 was admitted to the facility on 10/28/19. R27's Preventive Health Care document indicated R27 was administered a first step tuberculin skin test (TST) on 10/29/19. R27 was to receive a subsequent required second step TST, however facility lacked documentation that it had been administered. During interview on 10/7/21, at 10:50 a.m. IP confirmed that R27 did not have documentation of a second TST being administered. According to new employee records requested facility did not have record of TB screening and a TST for nursing assistant (NA)-11, NA-12, NA-13, licensed practical nurse (LPN)-7, registered nurse (RN)-4 and trained medication assistant (TMA)18. During interview on 10/7/21, at 10:50 a.m. IP-A stated facility did not have documentation of TB screening and TB test results of any kind for (NA)-11, NA-12, NA-13, LPN-7, RN-4 and TMA-18. During interview on 10/7/21, at 12:58 p.m. DON stated the expectation for the facility for timing of the TB risk assessment would be to follow the facility policy. In addition, DON stated the facility would follow the facility policy for TB testing residents and TB screening and testing staff upon hire and maintain documentation of screening and testing. A facility policy, reviewed 6/19/19, titled Tuberculosis Control Program indicated, " A facility Risk Assessment will be completed annually for each community." During interview	21426		

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21426	Continued From page 4	21426		

on 10/7/21, at 12:58 a.m. DON stated the language in the policy referred to the expectation that an annual TB risk assessment would be completed annually by the facility and the facility would preserve documentation of the risk assessment.

A facility policy titled Tuberculosis Screening of Residents, dated June 2017 stated, "All new admissions receive a TST within 72 hours of admission if there is no documented TST results within 90 days of admission.

A facility policy titled, Tuberculosis Program for Associates dated 10/30/19 indicated "Every new associate will begin by filling out the Personal Risk Assessment and Symptom Review ...For communities in MN, MO and ND and WI, or those that have a positive risk assessment, a tuberculin skin test (TST) or blood test (QuantiFERON) or T-spot), depending on community preference, will be performed on newly hired associates." "All reports or copies of the TST or blood work and any related chest x-ray and medical evaluation will be maintained in the associate's record"

SUGGESTED METHOD FOR CORRECTION: The director of nursing would ensure the TB risk assessment would be completed according to the CDC recommendations. In addition, the could monitor or designate staff to monitor that all new residents and all new staff have TB screening and TB testing done according to CDC guidelines.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.