DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2023

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

RE: CCN: 245255
Cycle Start Date: February 16, 2023

Dear Administrator:

On March 8, 2023, we notified you a remedy was imposed. On March 22, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 20, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 23, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 8, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 23, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 20, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Correction of the Life Safety Code deficiency(ies) cited under K541 and K918 at the time of the February 16, 2023 standard survey, has not yet been verified. Your plan of correction for this deficiency / these deficiencies, including your request for a temporary waiver with a date of completion of June 22, 2023, forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency / these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

REVISED LETTER. DPOC REMEDY REMOVED. PLEASE DISREGARD LETTER RECEIVED ON 3/8/23.

Electronically delivered

March 8, 2023

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

RE: CCN: 245255
Cycle Start Date: February 16, 2023

Dear Administrator:

On February 16, 2023, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 23, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 23, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 23, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 23, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cerenity Care Center On Humboldt will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 23, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Renee McClellan, 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: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@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 02/16/2023

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 On 2/13/23 through 2/16/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=E	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), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] 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), §485.542(e)(1),	E 041		3/20/23

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

Electronically Signed | 03/16/2023

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location 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), §485.542(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),§485.542(e)(2) 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), REHs at §485.542(g), and 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	E 041		

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E 041	Continued From page 2 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 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..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record (document) review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems. Findings include: During inspection of the facility generator by the state fire marshall the following were revealed: 1. On 02/14/2023 between 9:00 a.m. and 3:00 p.m., it was revealed by a review of available documentation, no documentation was presented to confirm the weekly inspections of the emergency generator being completed. 2. On 02/14/2023 between 9:00 a.m. and 3:00 p.m., it was revealed by a review of available documentation, no documentation was presented to confirm that monthly inspections of the emergency generator being completed. 3. On 02/14/2023 between 9:00 am and 3:00 p.m., it was revealed by a review of available documentation, no documentation was presented to confirm the required once every 36 months - 4 hour continuous run of the emergency generator being completed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	E 041	E041: Hospital CAH and LTC Emergency Power Findings include: 1. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the weekly inspections of the emergency generator is being completed. 2. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that monthly inspections of the emergency generator is being completed. 3. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the required once every 36 months - 4 hour continuous run of the emergency generator is being completed. Detailed Description of the corrective action taken or planned to correct the deficiency 1. Have obtained weekly inspection form for required testing and will start conducting weekly inspections on or before 04/15/23 2. Have obtained monthly inspection form for required testing and will start conducting monthly inspections on or before 04/15/23 3. Will schedule 36-month 4-hour continuous run on or before the waiver date of June 20, 2023 Address the measures that will be put in	

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E 041	Continued From page 4	E 041	place to ensure the deficiency does not reoccur 1. Weekly TELS task to remind ES director of required testing 2. Monthly TELS task to remind ES director of required testing 3. 36-month TELS task to remind ES director of required testing Indicate how the facility plans to monitor future performance to ensure solutions are sustained 1. ES director will review weekly log report to ensure completion 2. ES director will review monthly log report to ensure completion 3. Pioneer critical power and ES director will ensure 36-month 4-hour run is completed Identify who is responsible for the corrective actions and monitoring compliance Director of Environmental Services or Designee The actual or proposed date for completion of the remedy 03/20/23	
F 000	INITIAL COMMENTS On 2/13/23,2/14/23,2/15,23 and 2/16/23, a standard recertification survey was conducted at your facility. 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. The following complaints were reviewed, with no deficiency issued. H52558404C (MN90570),	F 000		

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F 000	Continued From page 5 H52557618 (MN90126), H52558402C (MN 90975), H52558403C (MN90733), H52558405C (MN89465), H52558406C (MN86396), and H5255130C (MN81850). 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident self-administration of medications (SAM) was carried out in accordance with the SAM assessments for 3 of 3 residents (R1, R21, and R62) reviewed for SAM. Findings include: R1's quarterly Minimum Data Set (MDS) dated 2/8/23, identified R1 had intact cognition and required extensive assist with transfers and	F 554	Humboldt POC This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	3/20/23

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F 554	Continued From page 6 supervision and set up help only for eating. R1 had a functional limitation in range of motion on one side of the body for upper and lower extremities. R1 had diagnoses of cerebral palsy, diabetes, heart failure and history of stroke. R1's SAM assessment dated 12/22/22, identified R1 wanted to and could appropriately SAM including eye drops, inhalers, nasal sprays and diclofenac (a prescription topical anti-inflammatory) gel and these medications would be stored in R1's room. R1's care plan dated 2/9/23, identified R1 wanted to SAM albuterol inhaler and prescribed eye drops and medications approved for SAM could be kept at R1's bedside. Approaches included R1 could safely administer eye drops, inhalers and diclofenac gel with written order and approval from nurse practitioner (NP). Additionally, R1 would frequently hoard over the counter (OTC) medications without prescription. Approaches included to inform the NP immediately if medications were noted inside resident's room which were not prescribed. The care plan lacked approaches to ensure medications stored in R1's room were reviewed to ensure they were not expired. R1's Physician Order Report dated 1/16/23 - 2/16/23, identified the following medications with start and end date: -11/3/22 open ended: albuterol sulfate HFA aerosol inhaler 90 mcg/actuation two puffs inhalation for shortness of breath as needed every four hours -11/3/22 open ended: diclofenac sodium gel 1% apply two grams topically to affected areas four times a day	F 554	F Tag: 554 Resident Self Admin Meds-Clinically Appropriate Self-Administration Medication Observation for R1, R62 and R21 were completed. Orders for Self-Administration Medication for R1 and R62 were obtained. R21 was determined not to appropriate to self-administer medications. Care plans were updated to reflect Self-administration. IDT team reviewed all Residents to determine if Self-Administration is appropriate. Residents with current Self-administration orders were reviewed to ensure the observation is accurate, orders are current and care plan is updated. Orders entered to check expiration dates monthly of all medications being Self-administered. Self-administration of medications policy was reviewed and remains current. Education was provided to nurses and trained medication aides on the Self-administration of medication policy, the process of checking for a self-administration order prior to leaving any medications unattended with a resident, and the importance of obtaining an order, completing observation and updating care plan on any resident who is appropriate to self-administer. Additionally, all staff were educated on immediate reporting of any medications observed unattended in resident rooms. DON or Designee will audit 3 resident med passes per unit per week for 3 months. Audit results will be submitted to Quality Council for review and determination of ongoing frequency and	

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	245255	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 554	Continued From page 7 -11/8/22 open ended: staff needs to administer all eye drops as directed (this conflicted with the assessment and care plan that R1 could SAM eye drops) -11/8/22 open ended: latanoprost (prescription eye drops for glaucoma) eye drops 0.005 % one drop both eyes at bedtime -11/8/22 open ended: latanoprost medication needs to be kept in the refrigerator or at room temperature for up to 6 weeks -11/8/22 open ended: ocean spray 0.65% spray two sprays nasal four times daily as needed for nasal congestion -11/8/22 open ended: Preparation H (phenyleph-min oil-petrolatum) ointment; 0.25-14-74.9 %; amt; insert rectally four times daily as needed for hemorrhoids -12/21/22 open ended: may SAM all eye drops, all inhalers and diclofenac gel and may leave at bedside -2/14/23 open ended: biotin (vitamin B7 supplement) oral capsules 1,000 micrograms (mcg) take one capsule daily in the morning. During an observation and interview on 2/13/23, at 1:12 p.m. R1 was in bed. On the shelf next to her bed there was a mostly empty bottle of biotin 5,000 mcg softgels, a mostly full 3-ounce bottle of saline nasal spray with a stamped expiration date of 11/2020. On R1's nightstand there was a mostly empty tube of Preparation H ointment. On her bedside table there was an inhaler and bottle of eye drops. R1 stated she took these medications independently. During an interview on 2/14/23, at 3:37 p.m. licensed practical nurse (LPN)-B stated SAM assessments were completed upon admission and quarterly. If a resident was appropriate to	F 554	duration. Completion Date: March 20, 2023	

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F 554	Continued From page 8 SAM, a physician's order needed to be obtained for the specific medications. LPN-B stated she had observed the above medications in R1's room. LPN-B reviewed R1's SAM assessment and orders and stated R1 could self administer creams, eye drops and inhalers. LPN-B agreed there were no physician orders for biotin at this time and no SAM for Preparation-H. During an interview on 2/14/23, at 3:39 p.m. registered nurse (RN)-A stated R1 would have medications brought into her room and that R1 had been advised to update nursing staff on new medications. RN-A entered R1's room and found the following medications which should not have been in use: - latanoprost eye drop bottle with an open date of 11/18/ (unreadable year). This medication was only good 6 weeks after being opened per physicians order so was considered expired, -meclizine foil punch out card of 10 tablets with 3 tablets remaining (there was no physician's order in place for this medication), -Preparation H mostly empty tube (no assessment or order to SAM), -biotin 5,000 micrograms mostly empty and an empty bottle of biotin 1,000 mcg (at this time there was no physician's order in place for this medication), -saline nasal spray partially empty which expired in 11/2020. RN-A removed the above medications after a discussion with R1 and stated she would follow up with the provider to obtain orders and ensure the SAM was appropriate. During an interview on 2/16/23, at 3:00 p.m. the director of nursing (DON) stated all medications residents wanted to SAM should be assessed	F 554		

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F 554	Continued From page 9 and stored properly for resident safety. R21's quarterly MDS assessment dated 2/6/23, identified R1 had severely impaired cognition and required extensive assist with transfers, bed mobility, and was independent with eating. R21 had no limitation in range of motion. R21 had diagnoses of Paroxysmal atrial Fibrillation (irregular heart beat), High blood pressure, Chronic Kidney Disease, and Vascular dementia (brain damage caused by multiple strokes). R21's SAM assessment dated 07/26/2022, identified R21 did not want to self administer any of his medications. R1's care plan dated 2/8/23, did not identify R21 wanted to SAM any medications. During an observation and interview on 2/14/23, at 8:28 a.m. R21 was in bed with his breakfast tray on an over the bed table. R21 had a med cup on his over the bed table with 2 light gold gel caps. When interviewed, R21 indicated not knowing what the medication was. During an interview on 2/16/23, at 8:47 a.m., RN-E indicated she administered R21 his medications on 2/14/23 and if he does not have his breakfast tray, she will leave the benzonatate capsules on the over the bed table, and go back and check on him when she picks up his breakfast tray. RN-E verified the light gold capsules are benzonatate. RN-E verified R21 does not have a SAM assessment, and if medications are left at the bedside, then a SAM assessment should be completed. During an interview on 2/16/23, at 11:15 a.m. the	F 554		

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F 554	Continued From page 10 Director of Nursing (DON) verified if medications are left at the bedside a SAM assessment should be completed. The Benedictine Self -Administration of Medication Policy dated 2020, indicated the following: 1. The nursing associates will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. Assessment is documented in the EHR (electronic health record). 2. The resident has the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. The IDT considers the following: a. The medications appropriate and safe for administration. b. The resident's physical capacity to swallow without difficulty and to open the medication bottles. c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for. d. The resident's capability to follow directions and tell time to know when medications are needed. 3. If it is determined a resident cannot safely self-administer medications, the nursing associates will administer the medications. 4. The nursing associates will routinely check self-administered medications and will remove expired discontinued or recalled medications.	F 554		

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F 554	Continued From page 11	F 554		

R62's annual MDS dated 1/4/23, indicated severe cognitive impairment and diagnoses of hemiplegia and hemiparesis (paralysis of one side of the body due to a stroke) following unspecified cerebrovascular disease (stroke), aphasia (disorder that affects communication) following cerebral infarction (damage or injury to the specific area in the brain) , adult failure to thrive (decline in older adults that affects their physical, mental, and social well-being), and moderate protein-calorie malnutrition. It further included R62 was totally dependent on staff with eating and toileting, and required extensive assistance with all other ADLs.

R62's physicians order dated 9/19/22, included ipratropium-albuterol, 0.5-3 miligrams (2.5 mg base)/3 mililiters, four times a day. These medications are used to treat and prevent symptoms (wheezing and shortness of breath) caused by ongoing lung disease.

R62's self administration of medication assessment dated 1/3/23, indicated R62 was not able to administer his own medications.

R62's care plan dated 2/3/23, included Medication Self-administration: Resident has been assessed by Interdisciplinary care plan team to be capable of self- administration of neb treatment with an intervention to monitor patient's administration of nebs and self administration.

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F 554	Continued From page 12 During continuous observation on 2/15/23, 8:57 a.m. to 9:15 a.m. R62 was laying in bed with a nebulizer mask over his nose and mouth. The nebulizer was running and the cup containing the medication was empty. There were no staff in the room. At 9:14 a.m. licensed practical nurse (LPN)-A went into R62's room and removed the nebulizer mask and turned off the machine. During an interview on 2/15/23, at 9:15 a.m. LPN-A stated she didn't remember what time she started R62's nebulizer treatment and it usually takes about 20 minutes to administer the treatment. LPN-A further stated she leaves the room during R62's nebulizer treatment but she comes back and checks on him. During an interview on 2/16/23, at 9:28 a.m. registered nurse manager (RN)-E stated the nurses are responsible for setting up the nebulizer treatment and then "I suppose they can come back." RN-E further stated the nurses should be monitoring R62 throughout the treatment and checking on him because R62 can't talk or use his call light. During an interview on 2/16/23, at 12:10 p.m. LPN-A stated she went back and checked on R62 several times during his nebulizer treatment on 2/15/23, contrary to the continuous observation on 2/15/23, from 8:57 a.m. to 9:15 a.m. No staff were observed checking on him between 8:57 a.m and 9:13 a.m. During an interview on 2/16/23, at 2:50 p.m. the director of nursing (DON) stated the nurses should be monitoring R62 throughout his	F 554		

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F 554	Continued From page 13 nebulizer treatment and 18 minutes was too long to go without montioring him.	F 554		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the surety bond contained sufficient funds to insure and protect the residents' trust fund, which had the potential to affect 32 residents who kept personal funds with the facility. Findings include: The facility current balance report dated 2/16/23, revealed the current balance of the fund at $29,797.29. The facility's surety bond (legally binding contract protecting the trust fund), active from 7/21/22 to 7/21/23, contained a sum of $27,000. A sum which was inadequate to cover the current amount of the resident trust fund. During interview on 2/16/23, at 2:27 p.m. the administrator produced a surety bond through USA Insurance Service, LLC for $27,000. The administrator verified the surety bond amount did not cover the amount the residents had in their trust accounts.	F 570	F Tag: 570 Surety Bond-Security of Personal Funds Surety bond was updated from $27k to $50k to cover all resident accounts. Resident Trust Account Policy was reviewed and remains appropriate. Resident account list will be reviewed monthly by Administrator or designee for 3 months to ensure accounts do not exceed amount of surety bond. Audit results will be submitted to Quality Council for review and determination of ongoing frequency and duration. Completion Date: March 20, 2023	3/20/23

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F 570	Continued From page 14 Review of the facility Resident Trust Account Policy last reviewed 12/9 21 revealed the following prcedure: 1. Establish the Resident Trust Account: - Establish an interest bearing checking account specific to resident trust funds. - A minimum of two check signers from the facility are required. The Business Office Manager is not able to be a check signer. The employee handling the resident trust should not be a signer on the bank account. - The BHS Director of Financial Services or a corporate designee will also be an authorized check signer. - The community will have a surety bond in the amount equal to or greater than the Resident Trust Account balance. - Monthly, the Resident Trust Designee shall verify the balance of the trust account to ensure proper coverage. If the coverage is insufficient or the balance increases significantly during the year, the Resident Trust Designee will work with their Regional Director of Finance to have coverage increased.	F 570		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those	F 582		3/20/23

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F 582	Continued From page 15 services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of	F 582		

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F 582	Continued From page 16 these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the notice of provider non-coverage (CMS 10123), or generic notice, upon discontinuation of Medicare part-A services for 1 of 3 residents (R17) reviewed for beneficiary protection notification. Additionally, the facility failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055) was provided to 2 of 3 residents (R17 and R40) who continued to reside in the facility upon termination of Medicare A benefits. This had the potential to affect all residents residing in the facility. Findings include: R17's skilled nursing facility (SNF) Beneficiary Protection Notification Review form completed with the facility identified R17's last covered day of part A service was 11/3/22. R17's form lacked documentation that CMS-10123 or CMS-10055 form was provided. R40's skilled nursing facility (SNF) Beneficiary Protection Notification Review form completed with the facility identified R40's last covered day of part A service was 2/17/23. R40's form lacked documentation that the CMS-10055 form was provided. During an interview on 2/16/23, at 2:31 p.m. social services (SS)-A confirmed it was a team effort to complete beneficiary forms for residents in the facility. SS-A indicated she was unsure why R17 did not get either CMS-10123 or CMA-10055. SS-A indicated she was unsure why	F 582	F Tag: 582 Medicaid/Medicare Coverage/Liability Notice Residents x 2 that were identified were reviewed: R17 discharged from the facility. R40 admitted on 1/19/23 under MCR A and switched to Healthpartners MSHO on 2/1/23. R40 was issued a Notice of Medicare Noncoverage, however, did not need an ABN issued due to changing from MCR A to Healthpartners MSHO partway thru her stay. Current Medicare A skilled residents were reviewed for set Last covered days to determine the proper forms to issue, documentation needed and the process to upload into electronic medical record. Medicare Beneficiary Notice Policy was reviewed and remains appropriate. Current procedure includes review of all MCR A skilled residents in IDT morning meeting and PDPM meeting. Current procedure of confirmation of Last Covered Day for MCR A skilled residents every week after therapy meeting continues. Clinical Reimbursement and Social Service members were reeducated on ABN/NOMNC issuance, documentation, and uploading into electronic medical record. Administrator or designee with audit all MCR A skilled residents for ABN/NOMNC completion/issuance/documentation/uploa d x 4 weeks and then 2 residents x 2 months. Audit results will be submitted to Quality	

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F 582	Continued From page 17 R40 did not get CMS-10055 but to speak with registered nurse (RN)-C who writes the forms up needed to be given. On 2/16/23, at 2:44 p.m. RN-C stated as of right now she is the one who gets the CMS-10055 and CMS-10123 forms ready and gives them to SS to get the signatures. RN-C stated she then uploads then and keeps the original. RN-C was unable to find either document for R17 and was unable to find CMS- 10055 for R40. On 2/16/23, at 2:53p.m. the administrator stated as soon as the facility knows the last covered day, the facility should get the forms signed so the resident has time to appeal if they wanted. The resident should get the form as soon as possible but within 48 hours of non-coverage. The facility policy Medicare Beneficiary Notices reviewed on 11/17, indicated the facility would provide beneficiary notices according to Medicare guidelines.	F 582	Council for review and determination of ongoing frequency and duration. Completion Date: March 20, 2023	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		3/20/23

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F 585	Continued From page 18 §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all	F 585		

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	245255	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 585	Continued From page 19 information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance	F 585		

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F 585	Continued From page 20 decision. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review the facility failed to process resident concerns or grievances to ensure prompt resolution for 1 of 1 resident (R8) reviewed for missing personal property. Findings include: R8's significant change in status Minimum Data Set dated 11/20/22, identified R8 had intact cognition and it was very important to be able to choose what clothing she wore. During an interview on 2/13/22, at 12:31 p.m. R8 stated she had been missing several pants and shirts and had mentioned the missing items to the laundry assistant (LA) a couple of months ago. R8 stated she had not received her missing clothing since she brought it up. During an interview on 2/15/23, at 7:42 a.m. the LA stated R8 had told her about the missing clothing. The LA stated she then checked the unclaimed laundry bins and could not find R8's clothing. The LA stated R8's clothing potentially got mixed up in the industrial laundry which was shipped out. The LA stated she should have updated the social worker since she could not find the missing clothing for R8 and she had not. The LA stated resident clothing comes down unmarked often and it would be helpful if the facility labeled clothing and had a type of log she could enter the missing clothing in once reported and track when it was recovered. During an interview on 2/15/23, at 12:58 p.m. the	F 585	F Tag: 585 Grievances Concern for R8 was placed in the concern database. Search for missing items was conducted and alleged missing items were not found. R8 missing items were replaced to the satisfaction of the resident. Laundry aide was inserviced on communication expectations when a concern is brought to her attention No other identified past due concerns not entered in the concern database. All staff have been inserviced on grievance process and expectations. The Missing Items Policy was reviewed and remains current. Administrator or designee will audit 5 grievances per month x 3 months for proper process being followed All results will be submitted to Quality Council for review and determination of further audits Completion Date: March 20, 2023	

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F 585	Continued From page 21 administrator stated R8 had no logs of missing clothing in the concerns data base. The adminsitrator stated if a resident had missing personal items she would expect staff to let a supervisor know so it could get logged in the concerns data base to ensure follow up. During an interview on 2/15/23, at 1:09 p.m. the social services (SS)- B stated he met with R8 and logged her missing clothing into the concerns data base today and would follow up on it. The facility policy Concerns, Grievances dated 9/17/19, identified when a resident voiced a concern to staff member, the staff member would complete a concern form and forward the form to the social services department, grievance officer or designee. The facility would then ensure a prompt response to acknowledge receipt of the concern, investigate, seek a resolution and keep the resident apprised of progress toward resolution. the resident had a right to also receive a written response to their concern if requested.	F 585		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		3/20/23

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F 655	Continued From page 22 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was completed for 1 of 1 resident (R383) reviewed for communication. Findings include:	F 655	F Tag: 655 Baseline Care Plan Baseline care plan for R383 was completed on 2/16/23. Admissions since 2/1 were audited and to ensure they had a baseline or comprehensive care plan completed as	

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F 655	Continued From page 23 R383 face sheet dated 2/16/23, indicated R383 was admitted to the facility on 2/7/23. R383's care plan reviewed/revised on 2/14/23, indicated a baseline care plan was created on 2/13/23. The baseline care plan lacked communication interventions, therapy services, and social services needed to provide effective and person-centered care. During an interview on 2/15/2023, at 12:11p.m. registered nurse (RN)-B stated baseline care plans should be done on admission and consist of ADLS, names, vision, eating, assistance, pain, restraints, cultural, behaviors, and social services. RN-B confirmed R383 did not have a completed baseline care plan. On 2/16/2023, at 9:18a.m. the social services director (SSD) stated the resident should be offered a baseline care plan and a complete care plan per our policy. On 02/16/2023, at 10:54a.m. the director of nursing (DON) stated she would expect the staff to complete a baseline care plan to each resident within 48 hours of admission. The facility policy Comprehensive Assessments and Care Planning reviewed/revised on 7/2/18, indicated the facility would develop a baseline care plan within the first 48 hours of admission.	F 655	indicated. The Comprehensive Assessments and Care Planning Policy was reviewed and remains current. The interdisciplinary team was educated on the expectation to complete baseline care plans within 48hrs of admission and to offer care plan summary and documentation of acceptance or declination for initial care conferences. Director of nursing or designee with audit 3 new admits weekly x 3 months for completion of baseline care plan and documentation of offering care plan at initial care conferences. Audit results will be submitted to Quality Council for review and determination of ongoing frequency and duration. Completion Date: March 20, 2023	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		3/20/23

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F 677	Continued From page 24 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff provided adequate grooming for 1 of 1 resident (R53) reviewed for activities of daily living (ADL). Findings include: R53's quarterly Minimum Data Set (MDS) dated 1/2/23, indicated moderately impaired cognition and diagnoses of chronic kidney disease (stage 4), chronic obstructive pulmonary disease, and need for assistance with personal care. R53 required limited assistance with personal hygiene. R53's care plan last revised 1/3/23, indicated self care deficit in dressing, grooming and bathing due to unilateral primary osteoarthritis (breakdown of joint tissue) to right hip, chronic obstructive pulmonary disease (constriction of airways which makes it hard to breathe), chronic systolic (congestive) heart failure (heart doesn't pump blood effectively) ,chronic kidney disease, and pain with an intervention to assist with dressing, grooming, and bathing. R53's nursing assistant care sheet (undated) indicated nurse to trim nails on bath day. Bath day on Thursday a.m. (morning). During observation on 2/13/23, at 1:00 p.m. R53 had several long fingernails (approximately one-half of an inch) on both hands. R53 stated he wanted his nails to be cut and he had asked several times and no one would cut them.	F 677	F Tag: 677 ADL Care Provided for Dependent Residents R53 nails were trimmed on 2/15/23. All residents were observed for long fingernails and offered nail care. ADL Policy was reviewed and remains current. RN/LPN/CNA In-Service was completed on nail care completion with bath days. DON or designee will audit 5 residents for completed nail care weekly x 3 months. Audit results will be submitted to Quality Council for review and determination of ongoing frequency and duration. Completion Date: March 20, 2023	

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F 677	Continued From page 25 During observation on 2/15/23, at 2:15 p.m. R53 stated staff still hadn't cut his nails and was observed to have several long fingernails on both hands. During interview on 12/16/23, at 12:16 p.m. registered nurse (RN)-F stated they (staff) are supposed to document refusals in regards to cutting a residents nails. During an interview on 2/16/23, at 9:28 a.m. nurse manager RN-A verified nurses are responsible for cutting R53's nails and was unable to find any documentation his nails had been cut or he had refused. During an interview on 2/16/23, at 2:50 p.m. the director of nursing (DON) stated generally she would expect staff to document refusals of care but didn't think there was an option for refusing nail care specifically. The DON verified there was no way of knowing whether the nurse offered to clip a residents nails or if the resident had refused, as there was no documentation. The facility's policy titled activities of daily living dated 2/21, indicated residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		3/20/23

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F 686	Continued From page 26 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement pressure ulcer interventions for 3 of 5 residents (R59, R43, R73) identified at risk for pressure ulcers. This resulted in actual harm when R59 developed three unstageable pressure areas, one stage III pressure area and one stage IV pressure area after admission and actual harm when R43 developed a stage III pressure ulcer after admission. Findings include: Stage II pressure ulcer: partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage III pressure ulcer: full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant	F 686	F Tag: 686 Treatment/Services to Prevent/Heal Pressure Ulcer R59 medical record has been reviewed with Quality Council Committee for process improvement opportunities. Weekly skin assessment order added to R59's orders starting 2/14/23. Weekly skin assessment order added to R43's orders starting 2/15/23. On 3/2/23, IDT reviewed Braden risk scores for R59 and R43 and care plans were reviewed for appropriate interventions in place to prevent further skin breakdown. A head-to-toe inspection was completed for R73 on 3/9/23 to ensure no new pressure areas were present. All residents have been visualized for impaired skin integrity and appropriate interventions implemented as indicated. IDT reviewed all residents to ensure individualized preventative measures are in place for any resident at risk for pressure injuries.	

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F 686	Continued From page 27 adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Stage IV pressure ulcer: full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. Unstageable pressure injury: obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage III or Stage IV pressure injury will be revealed. R59's significant change Minimum Data Set (MDS) dated 11/28/22, identified R59 had severe cognitive impairment and required extensive assistance for bed mobility, transfers, dressing, eating, and personal hygiene. R59 had not walked. R59 required total assistance with toileting. R59 had diagnoses of dementia and diabetes. Further, the MDS outlined R59 was at risk for developing pressure ulcers, however, had no current pressure ulcers or injury. R59's care plan reviewed/revised 2/14/23, indicated R59 was at risk for pressure ulcer due to friction, shear, nutrition, bedfast/ mobility and impaired sensory perception. The interventions included elevate heels off bed or use heel protectors, encourage family to bring in favorite food, monitor for infection, nutritional consult, offer small frequent meals, provide nutritional supplement as ordered, teach patient to do	F 686	Pressure Injury Policy has been reviewed and remains appropriate. All nursing staff have been reeducated on the Pressure Injury Policy. Nurses, TMAs, and CNAs were educated on turning/repositioning per care plan, completing weekly skin assessments, completing the initial skin assessment and implementing interventions upon admission, Braden risk scores and interventions, and the responsibility of checking skin daily and reporting any redness or breakdown to the nurse. Weekly skin assessments have been added to the treatment record and will be added for all new admissions going forward. IDT will review Braden scores weekly to implement interventions as appropriate. DON or designee will audit all new admissions x 3 weeks then 3 new admissions x 9 weeks to verify orders are in place for weekly skin monitoring, initial skin assessments and care plan interventions are in place. Additionally, 3 residents per unit per week x 3 months will be audited to verify that weekly skin checks are completed, documented and appropriate interventions implemented if indicated. 3 residents who have turning/repositioning care plans will be audited per unit per week x 3 months to verify compliance. Audit results will be submitted to Quality Council for review and determination of ongoing frequency and duration.	

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F 686	Continued From page 28 frequent small shifts of body weight if able, treatment as ordered, weekly wound rounds scheduled, wound vac to sacrum in place as ordered, air mattress in place, repositioning patient every 2-3 hours, minimum of two people plus draw sheet to lift resident while in bed, and skin inspection every incontinence care with close attention to heels and other pressure areas. R59's Skin Risk Assessment with Braden Scale dated 10/19/22, indicated R59 was at risk due to diabetes, incontinence of bowel and bladder, slightly limited sensory perception, chairfast, slightly limited mobility, and friction and shearing being a potential problem. The assessment lacked any interventions. On 11/28/22 R59's Braden score was 13 the interventions were to apply barrier cream and to turn and reposition. With a Braden score of 13 and the interventions to apply barrier cream and to turn and reposition the facility increased the risk for R59 to develop pressure areas. R59's Admission Body Audit: Skin Condition dated 10/19/22, indicated all skin was intact. R59's Weekly Bath Day Body Audit Form dated 10/25/22, indicated all skin was intact. R59's Weekly Bath Day Body Audit Form dated 11/16/22, indicated all skin was intact. R59's Weekly Bath Day Body Audit Form dated 1/11/23, indicated no new skin issues, had non-verbal pain indicators, cause was from R59's buttocks. R59's Weekly Bath Day Body Audit Form dated 1/31/23, indicated a scar on right ankle measuring 2 centimeters (cm) x 2 cm, a scab on left ankle measuring 2 cm x 1.5 cm, a pressure	F 686	Completion Date: March 20, 2023	

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F 686	Continued From page 29 ulcer on left heel measuring 3 cm x 3.5 cm, and a pressure ulcer on sacrum measuring 10 cm x 9 cm. R59's Weekly Bath Day Body Audit Form dated 2/15/23, indicated no new skin issues noted except dry skin on her lower extremities. There was no evidence in R59's electronic medical record (EMR) that weekly skin audits had been completed between 11/17/22 through 1/10/23. R59's progress note dated 12/20/22, indicated purplish blister on her left heel measuring 4.5 cm x 4 cm, with necrotic (death of body tissue) wound on left ankle measuring 2 cm x 2 cm and on left outer foot which is 1 cm x 1 cm. Wound on right ankle is 1.5 cm x 1.5 cm. R59's progress note dated 1/1/23, indicated an open area on the sacrum measuring 3 cm x 2 cm. R59's Physician Order Report dated 2/16/23, included the following orders: - 1/31/23, zosyn in dextrose 3.375 milligram/50 milliliter intravenously every 6 hours. - 1/31/23, wound vac to sacrum: Negative pressure on the pump is 125 millimeters of mercury continuous. Supplies needed for wound vac dressing change are medium black granuform. The pump must be delivering this amount of negative pressure for at least 22 out of 24 hours. If the pump alarms that pressure is not correct the warning "LEAK DETECTED" will show on the pump. If this occurs, please try to locate the leak by listening, and patch the air leak with clear tegaderm. If the seal cannot maintain for two hours, then the wound vac dressing will need	F 686		

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(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 686	Continued From page 30 to be removed and replaced with normal saline wet to moist dressing and notify medical director MD. - 2/2/23, Wound care (bilateral lateral ankles and left foot): Cleanse wound with normal saline and pat dry, skin prep to scabs, no dressing needed. - 2/2/23, Wound care (left heel): Cleanse wound with normal saline and pat dry, apply xeroform, cover with 4x4 mepilex. R59's Wound Evaluation and Management Summary physician notes identified the following: - 1/4/23, Right lateral ankle stage II pressure area measuring 1.5 cm x 2 cm, scabbed over, duration greater than 18 days. Unstageable deep tissue injury to left ankle measuring 2 cm x 1.7 cm, duration greater than 18 days. Unstageable deep tissue injury to left lateral foot measuring 1 cm x 0.9 cm, duration greater than 18 days. Unstageable due to necrosis of left heel pressure area measuring 5 cm x 3.2 cm, duration greater than 18 days. Stage III pressure wound to sacrum measuring 1.8 cm x 1.3 cm x 0.1 cm, duration greater than 10 days. Recommendations for all wounds was to off-load wounds, reposition per facility protocol, float heels in bed, sponge boot. - 1/18/23, Right lateral ankle pressure area unstageable due to necrosis measuring 1.8 cm x 1.8 cm eschar/scab is dry with no signs of infection. Left ankle unstageable pressure area due to necrosis measuring 2.2 cm x 2 cm scab/eschar (dead tissue) is dry and intact. Left lateral foot unstageable deep tissue injury measuring 1 cm x 0.8 cm with intact skin. Left heel unstageable pressure area due to necrosis measuring 3.5 cm x 3.7 cm. Sacrum unstageable pressure area due to necrosis measuring 6 cm x 8.2 cm, given the increase in size and new odor, recommended transfer to emergency	F 686		

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	245255	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 686	Continued From page 31 department. - 2/1/23, Right lateral ankle pressure area unstageable due to necrosis measuring 1.8 cm x 2 cm scab. Left ankle unstageable pressure area due to necrosis measuring 2.6 cm x 2 cm. Left lateral foot unstageable deep tissue injury measuring 0.8 cm x 1 cm with intact skin. Left heel unstageable pressure area due to necrosis measuring 3.2 cm x 3.7 cm x 0.2 cm. Sacrum stage IV pressure ulcer measuring 10 cm x 6.5 cm x 1 cm. - 2/8/23, Right lateral ankle pressure area unstageable due to necrosis measuring 1.2 cm x 1.2 cm scab. Left ankle unstageable pressure area due to necrosis measuring 0.4 cm x 0.3 cm. Left lateral foot unstageable deep tissue injury measuring 1 cm x 1 cm with intact skin. Left heel stage III pressure area measuring 3.2 cm x 3 cm x 0.2 cm. Sacrum stage IV pressure ulcer measuring 8.1 cm x 7.5 cm x 1.3 cm. During an observation on 2/14/23, at 03:55p.m. R59 was noted to have heel boots in place on bilateral feet. R59 had a pillow wedge under her right side. Wound vac noted to be intact with no soiling on wound vac. R59 was noted to have an air mattress. During an interview on 2/15/23, at 12:42p.m. the medical doctor (MD)-A stated the facility could have caught the pressure ulcers earlier if they would have been doing skin inspections weekly but would not have prevented the pressure areas from occurring. On 2/16/23, at 8:58a.m. RN-D stated the facility staff does body audits twice a week and then they are uploaded in the system. If staff find any skin concerns, they would call the on-call for the	F 686		

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F 686	Continued From page 32	F 686		

facility and they would direct us on what to do. The nurse manager is the one who puts interventions into place.

On 2/16/23, at 9:09a.m. registered nurse (RN)-B stated the facility staff do body audits on the fourth floor twice a week and then they are uploaded into the system. RN-B stated she was unable to find any other body audits for R59 other then what was already in the EMR.

On 2/16/23, at 10:08a.m. the director of nursing (DON) stated the staff are expected to complete a skin assessment upon admission and once or twice weekly for each resident. The DON stated the facility changed the process this week as the paper body audits were not being completed. R59's wounds might have been caught sooner if staff were doing body audits but it is hard to say. The DON confirmed the expectation for nurses is to do weekly skin assessments on all residents.

On 2/16/23, at 3:04p.m. the Medical Director stated he felt the "preventable and avoidable" pressure injuries to the bilateral lower extremities and the sacrum developed between 12/7/22 and 12/20/22.

R43's quarterly MDS dated 1/23/23, identified R43 had moderately impaired cognition and no rejection of care assessed. R43 was totally dependent on staff for bed mobility and transfers and had not walked. R43 required extensive

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F 686	Continued From page 33 assistance with dressing. R43 had no functional limitation in range of motion to his upper extremities and impairment on both sides of lower extremities. R43 had diagnoses of encephalopathy (altered mental state and confusion), diabetes, malnutrition and schizophrenia. R43 was at risk for pressure ulcer or pressure injury, however did not have a pressure ulcer or injury at the time of the assessment. Interventions included pressure relieving device for chair and bed and a turning and repositioning schedule. R43's Pressure Ulcer Significant Change Care Area Assessment (CAA) dated 5/12/22, identified R43 was admitted with no major skin concerns but was at risk for skin breakdown related to reduced mobility, reduced skin integrity, reduced strength, incontinence, and risk for shearing during transfers or repositioning. Resident had a pressure reducing device for chair and bed, and turning/repositioning program. R43 completed therapies with no new referrals and to continue care plan. R43's care plan dated 7/5/22, identified R43 was at risk for pressure ulcers due to a fracture of right patella, staphylococcus arthritis, schizophrenia, cognitive impairment, type two diabetes, encephalopathy, incontinence, catheter and dependence on mechanical lift for transfers. Interventions included monitor skin daily with cares and conduct systematic skin inspection weekly, remove immobilizer from knee and perform skin check twice daily. The care plan lacked intervention to address proper foot wear or other protective and preventative measures for R43's feet.	F 686		

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F 686	Continued From page 34 R43's Skin Risk Assessment with Braden Scale dated 1/23/23, identified he was at moderate risk due to cardiovascular disease, contractures, diabetes, hemiplegia, and catheter. History of or refusal of care was not checked on the assessment form. R43 had no pressure ulcers at the time of the assessment. R43 had a cast/brace/splint checked and elevated head of bed due to medical necessity. R43 had slightly limited sensory perception that would affect his ability to respond meaningfully to pressure related discomfort, pressure relieving device for chair, bed and was on a turning and repositioning schedule. The assessment lacked intervention to address proper foot wear or other protective and preventative measures for R43's feet. R43's Physician Order Report dated 1/16/23 - 2/16/23, included the following orders: -1/24/23: occupational therapy (OT) to eval and treat due to wound on the right sole of foot, cushion may be needed for the foot rest -1/25/23: right foot cleanse wound daily with wound cleanser and pat dry. Apply calcium alginate to open wound bed, wrap with kerlix and tape. R43's care plan dated 1/25/23, identified R43 had a stage II pressure ulcer located on the bottom of his right foot plantar (bottom of foot) region. R43 was at risk for increased skin integrity as indicated by the Braden score and comorbidities. Interventions included to wear heel protectors to protect heels while in bed and would be monitored for properly fitting footwear and pressure reduction to the heels. R43's OT Evaluation and Plan of Treatment dated 1/26/23, identified R43's right lower extremity	F 686		

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F 686	Continued From page 35 hung off the foot rest at each arch point of foot where there was now a wound. R43 required a different wheelchair and adaptive equipment to prevent skin breakdown to his lower extremeties. R43's Wound Evaluation and Management Summary physician notes identified the following: -1/11/23, treatment to a post surgical wound of the right knee and other wound to the leg was provided. There were no pressure sores identified on R43's foot -1/25/23, a stage II pressure wound of the right plantar foot was identified which measured 4.5 x 2.3 x 0.2 cm and treatments provided. Recommendations included offload the wound and sponge boots -2/1/23, the stage II pressure wound of the right plantar foot had deteriorated to a stage III pressure wound measuring 5 x 4.5 x 0.2 cm, the wound was debrided (removal of dead skin) and treatments provided -2/8/23, the stage III pressure wound of the right plantar foot had deteriorated and measured 5.5 x 6 x 0.4 cm and treatments provided. Redness was noted and antibiotics were ordered. During observations on 2/13/23, at 1:00 p.m., 2/14/23, at 9:00 a.m. and 2/15/23, at 9:00 a.m. R43 was observed to be able to self propel in his wheelchair using his hands. R43's legs were elevated on foot rests attached to the wheelchair. R43 had foam boots on both feet. During an interview on 2/14/23, at 3:07 p.m. NA-B stated she had worked with R43 frequently. R43 relied on staff to dress him. R43 had not worn shoes before he developed this current pressure ulcer on the bottom of his foot. NA-B was unsure if R43 had shoes. NA-B stated R43 would self	F 686		

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F 686	Continued From page 36 propel his wheel chair with his unprotected feet pushing on the foot rests. NA-B also stated R43's right foot curved over the foot rest so more pressure was on the foot rest. NA-B stated R43's knee immobilizer was discontinued after the wound developed so he could move his leg more. During an interview on 2/15/23, at 1:04 p.m. NA-A stated she worked regularly on the unit R43 resided on. NA-A stated R43 had not worn shoes probably due to a personal preference, she had not asked why R43 didn't have shoes on. NA-A stated R43 would self propel in his wheelchair with his legs up on the foot rests. NA-A stated the knee immobilizer made it harder for R43 to move his right leg and the pressure from the wheelchair foot rest lined up with the new pressure sore on the bottom of his foot. NA-A stated the knee immobilizer was now discontinued. During an observation on 2/15/23, at 2:08 p.m. with RN-A, RN-B, and MD-A wound treatment was provided to the right plantar pressure sore. MD-A measured the wound to be 5.5 x 4.7 x 0.4 cm which was slightly improved from the previous week. MD-A told R43 she wanted to remove more dead tissue but R43 declined and said yes when MD-A asked if the wound hurt while she worked on it. MD-A stated she would order a pain medication to be given prior to the treatment the next time she came and R43 agreed to reschedule the dead tissue removal next week. During an interview on 2/15/23, at 2:13 p.m. with RN-A, RN-B and MD-A together after wound care was provided, RN-A stated the cause of the pressure sore was R43's foot putting pressure on his wheelchair foot rest and that R43 was at higher risk for pressure sores to the way his right	F 686		

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F 686	Continued From page 37 foot dropped (weak in the front of the foot). Next, RN-B stated R43 had a diagnosis of being malnourished and this could contribute to R43's risk for pressure ulcers. MD-A then stated the wound was caught early, however she was unsure why the wound had deteriorated. MD-A stated a wound like this on R43 could develop in as little as two hours, and less than a day. MD-A stated pressure on R43's unprotected foot from the wheelchair foot rests while he self-propelled was the likely cause of the pressure sore. MD-A stated protection of the foot such as a shoe, something more than socks, could have prevented the pressure sore. During an interview on 2/15/23, at 2:20 p.m. RN-A stated R43 was at risk for pressure ulcers and his skin was monitored, however, the bottoms of his feet were not identified as a high risk area even though R43 had not worn shoes, had limited mobility to offload due to the knee immobilizer, his feet rested often on the wheelchair foot rests and R43 lacked protection to the bottom of his feet. During an interview on 2/16/23, at 9:14 a.m. the OT-A stated she had worked with R43 prior to and after the development of the pressure ulcer on the bottom of his foot. OT-A stated the wound developed on the arch of R43's foot which lined up with the wheelchair foot rests. Once the wound developed and then the leg brace was discontinued R43 could move his foot more to offload pressure. OT-A stated R43 only wore socks and was not able to move his foot off the wheelchair foot rest. OT-A stated they were now trying to find a new wheelchair so he could self-propel and protect his feet. OT-A stated the pressure from the foot rest on R43's unprotected	F 686		

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F 686	Continued From page 38 foot was the cause of the pressure ulcer and could have been prevented. During an interview on 2/16/23, at 10:24 a.m. the DON reviewed R43's record and agreed with the Braden assessment that he was at moderate risk for developing pressure ulcers. The DON reviewed R43's care plan and agreed foot wear or foot protection was not addressed in the care plan prior to the development of the pressure ulcer on the bottom of his foot. The DON agreed that the pressure sore on the bottom of R43's foot could have been prevented if the foot had been identified as a higher risk area. R73's quarterly MDS dated 12/8/22, indicated R73 had intact cognition and diagnoses of fracture of unspecified part of neck of left femur, pressure ulcer of sacral region (stage IV), muscle weakness, and need for asssitance with personal care. It further indicated R73 required extensive assistance with bed mobility (2 staff) and transfers and ambulation did not occur. R73 was at risk for developing a pressure ulcer, had (1) stage IV pressure ulcer (sacral region), and had an intervention of a turning/repositioning program. R73's care plan dated 9/5/22, include R73 was at risk for alteration of skin status due to fracture of unspecified part of neck of left femur with routine healing, cognitive communication deficit, diabetes mellitus type II, unspecified severe protein-calorie malnutrition, metabolic encephalopathy (neurological disorder resulted from systemic illness such as diabetes or organ failure and which can be reversed if treated), and pressure ulcer of sacral region, with an intervention of a turning and positioning program due to decreased mobility with assist of two. R73 prefers to be repositioned every three hours and requires	F 686		

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F 686	Continued From page 39 special attention when positioning related to pressure ulcer of sacral region. R73's nursing assistant care sheet (undated), indicated R73 should be repositioned every 2-3 hours. During continuous observation on 2/14/23, from 1:40 p.m. to 4:47 p.m. R73 was not repositioned timely. R73 was laying in bed on her back and remained in that position throughout the entire observation. At 3:08 p.m. NA-C entered R73's room with a vital signs machine and exited at 3:09 p.m. NA-C stated she took R73's vital signs and did not re-position her or offer to do so. No other staff entered R73's room. During interview on 2/14/23, at 4:45 p.m. NA-C stated R73 should be repositioned every two hours and the last time R73 was repositioned "was at 2:30 p.m. by the girl who worked the day shift." NA-C did not know the name of the staff. R73's medical record lacked any documentation R73 had been repositioned, offered to be repositioned, or refused to be repositioned. During interview on 2/16/23, at 2:50 p.m. the director of nursing (DON) stated staff should be repositioning R73 according to her care plan and even if R73 refused, staff should still be offering. The DON also stated staff should be documenting refusals. The facility policy titled Prevention and Treatment of Skin Breakdown/Pressure Injury undated, indicated weekly skin audits would be performed by a licensed nurse. The policy also indicated the	F 686		

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F 686	Continued From page 40 treatment for a pressure injury would include a weekly measurement, exam, and staging of the area.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the environment was free of accident hazards for 1 of 1 residents (R8) found to have a space heater operating in their room. Additionally the facility failed to ensure a safe smoking assessment was accurately completed and safe smoking practices implemented for 1 of 8 residents (R38) who smoked at the facility. Findings include: R8's significant change in status Minimum Data Set (MDS) dated 11/20/22, identified R8 had intact cognition. R8 had diagnoses of peripheral vascular disease (impaired blood circulation), arthritis and depression. R8 required extensive assist with transfers, supervision walking between locations in her room, and had no functional limitation in range of motion for upper or lower extremities.	F 689	F Tag: 689 Free of Accident Hazards/Supervision/Devices Spoke with identified smokers not smoking in designated area and asked them to only smoke in designated smoking areas. Smoking assessment was completed and updated for R38. Space heater in the room of R8 was removed. In real time, when identified, smokers are asked to smoke in designated smoking area only if they are seen to not be compliant. All smokers had a new smoking assessment completed for accuracy and implemented safe smoking practices as needed. Toured all areas and no other space heaters were found in resident care areas. Toured all offices and removed any unapproved space heaters. Meeting with the smokers about expectations occurred on 2/24/23 and ongoing as needed. Designated smoking area sign and more receptacles	3/20/23

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F 689	Continued From page 41 During an observation and interview on 2/13/23, at 12:38 p.m. R8 was sitting in her wheelchair in her room. There was a black Comfort Zone brand model number CZTV007 space heater on the floor with the power on. R8 said it was provided to her by the facility about one year ago to help warm her room. R8 said it would shut off if it was tipped or lifted. R8 stated she liked being able to adjust the temperature of her room this way. The Comfort Zone instructions for use, undated, identified the heater or fan would be hot when in use and extreme caution was necessary if used near disabled persons. During an interview on 2/13/23, at 1:27 p.m. nursing assistant (NA)-A stated R8 was the only resident she was aware of that had a space heater. NA-A stated she knew space heaters used to be prohibited in nursing homes and was unsure if they were approved at this time. During an interview and observation on 2/13/23, at 6:42 p.m. the administrator stated she was not aware of any space heaters in use for residents and space heaters were not allowed due to a fire hazard. The adminsitrator went into R8's room and agreed the space heater was in use and should be removed. The adminsitrator unplugged the space heater and removed it after a discussion with R8. Facility policy Extension Cord/Portable Space Heater Use dated 2/23, identified portable space heaters were not allowed in patient care areas. R38's quarterly MDS dated 12/27/22, indicated R38 had moderately impaired cognition and diagnoses of unspecified diastolic (congestive) heart failure (heart is unable to pump blood	F 689	purchased and placed in designated smoking area. All staff have been inserviced on the expectation of redirecting residents to the designated smoking area and nonuse of space heaters. Smoking Policy was reviewed and remains current. Portable Space Heater Policy was reviewed and remains current. Administrator or designee will do random audits will be conducted 3 times per weekday x 1 month and then 2 times per weekday x 2 months to ensure smokers are in the designated smoking area. Audit of rooms for compliance of no space heaters 1x weekly for 3 months. All results will be submitted to Quality Council for review and determination of further audits Completion Date: March 20, 2023	

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F 689	Continued From page 42 effectively), type 2 diabetes mellitus, and polyneuropathy (multiple nerves are damaged). R38 required extensive assistance with all activities of daily living (ADL). R38's care plan dated 9/28/22, indicated R38 had the potential for injury related to her choice to smoke with an intervention to instruct her on the faciity's policy on smoking location, times, and safety concerns. R38's smoking assessment dated 9/6/22, indicated R38 could be unsupervised to smoke and have smoking materials with her. During observation on 2/14/23, at 7:57 a.m. R38 was smoking in front of the main entrance of the building, not in the designated smoking area. During observation on 2/15/23, at 7:47 a.m. R38 was smoking in front of the main entrance of the building, not in the designated smoking area. During observation on 2/16/23, at 7:52 a.m. R38 was smoking in front of the main entrance of the building, not in the designated smoking area. During an interview on 2/16/23, at 2:50 p.m. the DON stated residents should be smoking in the designated area and not in front of the builidng. The DON also stated she would expect employee's who observe residents smoking in front of the building to direct them to the designated smoking area. During an observation on 2/16/23, at 7:52 a.m. the administrator verified R38 was smoking in front of the entrance to the building and not in the designated smoking area. The administrator also	F 689		

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	245255	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 689	Continued From page 43 stated employees who observe residents smoking in the front of the builidng are supposed to tell them they can't smoke in front of the building and direct them to the designated smoking area. The facility's policy regarding smoking (undated) included smoking is allowed ony in designated areas. This policy is consistently communicated to those individuals smoking in non-designated areas.	F 689		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was served at warm, palatable temperatures for 5 of 5 residents (R56, R65, R135, R45,and R8) who were observed to be served and/or complained about inappropriate food temperature. Findings include: Resident #56 R56's quarterly Minimum Data Set (MDS) dated 12/26/22, identified R56 had intact cognition and	F 804	F Tag: 804 Nutritive Value/Appear, Palatable, Prefer Temp Offered to warm up food for 5 residents with concerns or provided another option. Interviewed residents on all floors to determine needs/preferences of residents for warmth of food, offered other options or to heat up food as preferred. Culinary Director or designee will ensure hot plates or plate warmer and camduction system are being used properly for all meals. Culinary Director or designee will keep temp logs of food	3/20/23

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F 804	Continued From page 44 was independent with eating after staff set-up. R56's care plan dated 12/30/2022, indicated R56 had a potential for altered nutrition/hydration related to history of cerebral vascular accident (stroke) chronic obstructive pulmonary disease (COPD) (lung disease that makes breathing difficult), mild cognitive impairment, and morbid obesity (disorder involving excessive body fat). During an interview on 2/13/23, at 6:38 p.m. R56 stated "the food is not good, it is always cold." On 2/15/23 at 2:21 p.m., R56 stated the food "is still cold." R56 indicated "she will eat what she wants off of her meal tray." Resident #65 R65's quarterly MDS dated 12/8/22 identified R65 had intact cognition and was independent with eating R65's care plan reviewed 12/13/23 indicated R65 had a potential for altered nutrition/hydration R/T COPD, HTN (high blood pressure),obesity, lung nodule, and cognitive communication deficit. During an interview on 2/14/23 at 9:18 a.m., R65 stated "the food is served cold most of the time." R65 indicated will take the tray and go to the kitchenette and warm it up. R65 indicated they attended food council meetings every month, but nothing has changed, and believes it is because the food comes from a different building. Resident #135 R135 annual MDS dated 10/26/22 identified R135 had severe cognitive impairment, and	F 804	being plated in the kitchen at least 165 degrees and when it is served to residents at least 135 degrees. Culinary Director and Administrator received quote to purchase warming carts to utilize during transfer of trays from kitchen to skilled nursing facility. Policy of Maintaining Food Temp During Service was reviewed and remains current. Culinary Director or designee will audit each meal to ensure hot plates or plate warmers are being used for every meal Monday thru Friday x 6 weeks. Culinary Director or designee will audit 1 test tray per unit 5 times a week for 1 month and then 1 test tray per unit 3 times per week for 2 months for temps of food when placed in food carts in the kitchen and when they arrive to the resident to ensure it is at proper temperature. Culinary Director, Administrator, DON will review tray pass audits for concerns from residents during meal pass weekly x 3 months. Food Council meetings to be held in groups of residents and singular residents if unable to attend meeting for feedback on temperatures when food is delivered and follow up as necessary. All results will be submitted to Quality Council for review and determination of further audits. Completion Date: March 20, 2023	

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	245255	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 804	Continued From page 45 received supervision with eating. R135's diagnosis include: cerebral infarction (stroke) affecting right dominant side, type II diabetes, chronic kidney disease and bipolar disorder. R135's care plan last reviewed on 2/8/23 indicated R135 had a potential for altered nutrition/hydration R/T end of life care/on hospice, Nutritional decline, including weight loss and/or dehydration may be anticipated R/T end of life care. During interview on 2/14/23, at 10:14 a.m. R135 stated "the food is cold most of the time." R135 further stated "eats in the dining room." R45's MDS indicated R45 was cognitively intact and had diagnoses of congestive heart failure (the heart doesn't pump blood as well as it should), chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs.), and peripheral vasucular disease (narrowing of peripheral blood vessels). If further indicated R45 required supervison with eating (set up only). During an interview on 2/13/22, at 6:06 p.m. R45 stated the food was "always cold" and she has brought this issue up several times with the culinary services director (CSD) during food council. The food council meets 1-2 times a month and they discuss concerns specifically having to do with the food. R8's significant change in status MDS dated 11/20/22, identified R8 had intact cognition and was independent with eating after set up. R8's care plan dated 2/3/23, identified she was at risk for alteration in nutrition and hydration status	F 804		

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	245255	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 804	Continued From page 46 related to a history of failure to thrive, weakness and history of significant weight loss/gain. R8 was able to feed herself with meal set up and was able to verbalize nutrition needs. During an interview on 2/13/23, at 12:25 p.m. R8 stated "the hot food is not hot, it's cool to lukewarm when we get it" during meals. R8 stated it was an ongoing issue. R8 also stated she had not asked for food to be reheated "because that takes time and I don't like microwaved food reheated". During an observation and interview on 2/13/23, at 12:55 p.m. R8's ceramic lunch plate had rice and a pork chop on it. R8 touched her pork chop and said it was only "slightly warm". R8 also stated "I would like it to be hotter". During an interview on 2/14/23, at 3:59 p.m. the administrator stated the kitchen in the nursing facility required updated equipment so the dietary staff had to use the kitchen on the adjoining assisted living for over a year. During an additional observation and interview on 2/14/23, at 5:28 p.m. R8 had a ceramic plate with a hamburger on it for her supper meal and R8 stated her burger was "warm" and she "would like it hotter". During observation on 2/16/23, at 11:54 a.m. cook (C)-A and culinary services director (CSD) and three other unidentified culinary staff were preparing lunch meal trays. The main entree vegetable lasagna was temped at 189 degrees Fahrenheit (F). Chapter 4626 Department of Health Food Code dated 2019, identified stuffed pasta (such as lasagna) was required to be	F 804		

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F 804	Continued From page 47 cooked to 165 F or higher. -at 12:29 p.m. the 2nd floor food cart began to be loaded in the kitchen. Food from the steam table and refrigerated food and drink items were set on a room temperature tray, covered with a room temperature plastic insulated lid and placed in insulated unheated carts -at 12:45 p.m. the last of the 2nd floor food cart trays were placed in the cart. A test tray was requested. The test tray vegetable lasagna was temped at 171 degrees F and placed in the cart -at 12:50 p.m. the 2nd floor food cart was full and the CSD left with the cart to deliver it. The CSD pushed the food cart through the kitchen and into the assisted living hallways, up and down ramps, through elevators, through another adjoining independent living hallway and into the nursing facility (8 minute brisk walk) -at 12:58 p.m. the 2nd floor cart arrived at the 2nd floor unit and the first tray was delivered to the residents -at 1:07 p.m. the last tray was delivered to the residents on 2nd floor and the test tray was uncovered and temped by the DSC. The vegetable lasagna temped at 133 F in multiple areas -at 1:10 p.m. R8, who also resided on 2nd floor, was identified as the last resident to have her food delivered from the kitchen. With R8's permission the CSD took a temperature of her uneaten macaroni and cheese in an insulated bowl and the temperature was 115 F. The CSD stated that was too cool and offered to reheat it. R8 declined and stated she did not like to have her food microwaved. During an interview on 2/16/23, at 1:15 p.m. the CSD stated the food should be hotter for palatability, ideally at 165 F or more for lasagna,	F 804		

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F 804	Continued From page 48 but it was difficult to bring the food from the assisted living kitchen to the nursing home kitchen and maintain the temperatures. The CSD stated they had tried heated carts in the past but the carts were too heavy to have staff push them the distance from assisted living to the nursing home. The CSD stated they had not tried heating the plates first, before plating, to see if the food palatability improved. Facility policy Maintaining Proper Food Temp During Food Service, dated 8/2019, identified Food served would be maintained at proper hot and cold temperatures prior to and during meal service to assure food quality and tastiness/palatability as well as food safety. Hot food would be 135 F or higher during tray assembly and cold foods will be 41 F or less during tray assembly.	F 804		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		3/20/23

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F 883	Continued From page 49 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 883	F Tag: 883 Influenza and Pneumococcal	

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F 883	Continued From page 50 facility failed to ensure 3 of 5 residents (R388, R73, R55) were offered or received the pneumococcal pneumonia vaccine and failed to ensure 1 of 5 residents (R73) were offered or received the influenza vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R388's face sheet dated 2/16/23, indicated R388 had been admitted to the facility on 1/31/23. Review of R388's medical record on 2/16/23, lacked evidence of pneumococcal immunization, education, contraindication, and/or documentation of refusal by the resident or resident representative. R73's face sheet dated 2/16/23, indicated R73 had been admitted to the facility on 9/1/22. Review of R73's medical record on 2/16/23, lacked evidence of immunization, education, contraindication, and/or documentation of refusal of the pneumococcal and influenza vaccines by the resident or resident representative. R55's face sheet dated 2/16/23, indicated R55 had been admitted to the facility on 12/22/22. Review of R55's medical record on 2/16/23, lacked evidence of pneumococcal immunization, education, contraindication, and/or documentation of refusal by the resident or resident representative. During interview on 2/16/23, at 1:38 p.m. the infection preventionist (IP) and director of nursing	F 883	Immunizations R388, R73, and R55 were offered influenza and pneumococcal vaccines. R388 received Pneumococcal vaccine on 3/9/23. R73 refused influenza and pneumococcal vaccinations on 2/24/23. R55 agreed to receive the influenza and pneumococcal vaccines after enough time has lapsed since receiving the Covid vaccine on 3/10/23. Consents/declinations have been uploaded into each resident medical record. All residents were reviewed for influenza and pneumococcal vaccine consents or declinations and vaccinations offered as indicated. Influenza/Pneumococcal Policy have been reviewed and remain appropriate. Licensed nursing staff have been reeducated on offering vaccinations upon admission, completing a consent or declination for each resident and uploading the form to the medical record. DON or designee will audit new admissions x 3 weeks, then 3 residents per week x 9 weeks to verify that influenza/pneumococcal vaccines have been offered and administered or declined and consent/declination uploaded. Audit results will be submitted to Quality Council for review and determination of ongoing frequency and duration. Completion Date: March 20, 2023	

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	245255	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 883	Continued From page 51 (DON) stated they couldn't locate pneumococcal vaccines or declination documentation for R388, R73, and R55 and influenza vaccines or declination documentation for R73. The IP and DON verified all three residents should have been offered and/or administered the pneumococcal vaccine and R73 should have been offered and/or administered the influenza vaccine. The IP and DON confirmed their medical records lacked evidence of the pneumococcal and/or the influenza immunization, education, contraindication, and/or documentation of refusal by the resident or resident representative. The facility policy Pneumococcal Vaccines for Residents reviewed/ revised on 3/18/22, indicated upon admission and throughout a resident's stay, education, monitoring, and administration of pneumococcal vaccines would be provided. The resident's medical record shall include documentation that education was provided, the residents received and pneumococcal immunization or did not due to medical contraindication or refusal and would provide the resident with a current vaccination information sheet. The facility policy Influenza Vaccine for Residents dated 6/2017, indicated the facility would provide vaccine information, explain the risk, benefits, potential side effects, and would obtain a written consent or declination from all residents and/or responsible party which would be in the residents' chart.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The	F 887		3/20/23

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	245255	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 887	Continued From page 52 LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or	F 887		

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F 887	Continued From page 53 (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R28, R389, R73, R55) reviewed for COVID-19 vaccination status were offered the COVID-19 vaccine, and/or provided education regarding the risks, benefits, and potential side effects of COVID-19 vaccinations in accordance the Centers for Disease Control and Prevention (CDC) recommendations. Findings include: R28's face sheet dated 2/16/23, indicated R28 had been admitted to the facility on 12/27/22. Review of R28's medical record on 2/16/23, lacked evidence of immunization, education, contraindication, and/or documentation of refusal of the COVID-19 vaccine by the resident or resident representative. R389's face sheet dated 2/16/23, indicated R389 had been admitted to the facility on 2/3/23.	F 887	F Tag: 887 Covid 19 Immunization R28 was offered and declined vaccination on 2/21/23. R389 was offered and declined vaccination on 2/23/23. R73 was offered and declined vaccination on 12/27/22. R55 was offered and administered vaccination on 3/10/23. Consents/declinations have been uploaded into each resident medical record. All residents were reviewed for Covid 19 vaccination consent/declinations and offered as indicated. Covid 19 Policy and Vaccine Mandate have been reviewed and remain appropriate. Licensed nursing staff have been educated on offering vaccines upon admission, completing a consent or declination with each resident and uploading into the medical record. DON or designee with audit new admissions x 3 weeks, then 3 residents	

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 887	Continued From page 54 Review of R389's medical record on 2/16/23, lacked evidence of immunization, education, contraindication, and/or documentation of refusal of the COVID-19 vaccine by the resident or resident representative. R73's face sheet dated 2/16/23, indicated R73 had been admitted to the facility on 9/1/22. Review of R73's medical record on 2/16/23, lacked evidence of immunization, education, contraindication, and/or documentation of refusal of the COVID-19 vaccine by the resident or resident representative. R55's face sheet dated 2/16/23, indicated R55 had been admitted to the facility on 12/22/22. Review of R55's medical record on 2/16/23, lacked evidence of immunization, education, contraindication, and/or documentation of refusal of the COVID-19 vaccine by the resident or resident representative. During interview on 2/16/23, at 1:38 p.m. the infection preventionist (IP) and director of nursing (DON) stated they couldn't locate COVID-19 vaccines or declination documentation for R28, R389, R73 and R55. IP and DON verified all four residents should have been offered and/or administered the COVID-19 vaccine. The IP and DON confirmed their medical records lacked evidence of the COVID-19 immunization, education, contraindication, and/or documentation of refusal by the resident or resident representative. The facility policy COVID-19 Vaccine Policy	F 887	per week x 9 weeks to verify Covid 19 vaccines have been offered and administered or declined and consent uploaded to the medical record. Audit results will be submitted to Quality Council for review and determination of ongoing frequency and duration. Completion Date: March 20, 2023	

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 02/16/2023

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 887	Continued From page 55 reviewed/revised on 2/18/22, indicated the COVID-19 vaccine would be ordered from a long term care pharmacy or a local or state public health agency, or arrangements would be made with a vaccine provider to administer the vaccine to all residents. The facility would maintain documentation that education was provided, and that the vaccine was administered, contraindicated, or refused.	F 887		
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 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure housekeeping services for a clean environment for 9 of 9 resident rooms on the 3 east hallway (rooms,301, 302, 303, 304, 305, 306, 307, 308,and 309) and 5 of 13 rooms on 2 west hallway (room 244, 245, 247, 248, and 249) observed, and failed to ensure maintenance services for a safe environment for 1 of 1 room (room 302) observed. Findings include: During the screening process of residents on 2/13/23 and 2/14/23, the following rooms were observed to have debris stuck to the floor in the corner behind the hallway door and in the corner next to the door: room 301, 302, 303, 304, 305, 306, 307, 309, 244, 245, 247, 248, and 249.	F 921	F Tag: 921 Safe/Functional/Sanitary/Comfortable Environment Room 302 was checked for cracked ceiling paint and it was determined there is no imminent danger. Room 302 cracked ceiling was repaired on 3/10/23. Rooms identified were clean per expectations and loose debris on the floors was swept and mopped. A tour of all rooms identified additional rooms that required repair of cracked ceiling paint and painter is on site to complete the repairs. Tour of all resident rooms was conducted and rooms were cleaned according to audit findings. All housekeeping staff were inserviced for cleanliness expectations and given cleaning checklist. All staff were Inserviced on cleanliness expectations. A	3/20/23

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 02/16/2023

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 921	Continued From page 56 During interview on 2/13/23, at 6:56 p.m. R56 indicated they cleaned her room every other day or so. During interview on 2/14/23, at 9:18 a.m. R65 indicated housekeeping will come and "sweep her room every day, but if she spills something she will clean it up." During observation on 2/14/23, at 10:13 a.m. room 302 had three areas about one foot by one foot of peeling paint on the ceiling next to the window. Interview with R135 on 2/14/23 at 10:13 a.m., R135 stated the areas of peeling paint on the ceiling had been there "for months." During an environmental tour on 2/16/23, at 11:21 a.m., Environmental Service Director (ESD) verified there was debris behind the doors and commented "there is room for improvement in the cleaning of the rooms." The ESD indicated the facility had received a grant to paint rooms and verified the paint in room 302 was peeling and needed fixed. Review of invoices for Painting Express LLC. dated 1/23/22 through 2/13/23, did not include painting of room 302. The areas on the invoices were rooms 202, 203, 201, 246, 240, 242, 347, 2nd floor dining room, and 3 hallways on 2nd floor.	F 921	research of vendors to get bids for cleaning of stuck debris waxed into the floors is ongoing. A vendor has been secured to repair any cracked paint in resident rooms. Environmental Service Director or designee will audit 5 rooms weekly x 3 months for proper cleanliness and disrepair. All results will be submitted to Quality Council for review and determination of further audits. Completion Date: March 20, 2023	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245255	A. BUILDING: _____ B. WING _____	2/16/2023

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 569	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify 3 of 3 residents (R1, R6 and R19) who received Medicaid benefits when their personal fund accounts were within $200 of the allowed supplemental security income (SSI) limit. This deficient practice had the potential to affect 32 residents with personal fund accounts who received Medicaid and SSI. Findings include: The facility provided a Cerenity Care Center on Humboldt Current Balance Report dated 2/16/23, which listed 32 resident names. Upon review of the report, R1, R6 and R19 had reported amounts that were over the SSI limit. R1's account was $2511.57 over the limit, R6's account was $4355.78 over the limit, and R19's account was $49.25 over the limit. During an interview on 2/16/23, at 2:00 p.m. the billing office manager indicated she was new, had only been on the job for a month, had not had the opportunity to review the list of Medicaid residents and the balances in their accounts, and verified R1, R6 and R19 had reported amounts over the SSI limits of $3000 in Minnesota. She did not know how long the accounts had been over the limit. Review of facility policy titled Resident Trust Account last reviewed 12/9/21 indicated: 12. Asset Limitation Notification: The Medicaid limit varies by state. Refer to state guidelines for asset limitations. At month end close, the Resident Trust Designee creates the Current Balance Report from Matrix for balances of $1,800 or within $200 of the state guidelines whichever is lower. If a resident is within $200 of their Medicaid or SSI benefit limitation, send an Asset Limitation letter. (Letters can be generated from the Reports Tab, Resident Reports, and Create Resident Documents in Matrix). A copy of the letter should be saved in the month end folder on the Q drive.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245255	A. BUILDING: _____ B. WING _____	**2/16/2023**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 569	Continued From Page 1

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 _____	**02/14/2023**

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 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/14/2023. At the time of this survey, CERENTIY CARE CENTER 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		03/16/2023

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 **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 000	Continued From page 1 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. CERENTIY CARE CENTER 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 and was determined to be of Type II (222) construction.	K 000		

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

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K 000	Continued From page 2 Because the original building and the addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (222). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 93 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain facility means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2, 7.1.6.4, and 7.1.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 211	K211 Egress - Second floor - south lounge exit Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation that the 2nd Floor - South Lounge Exit from the structure exhibited coverage of snow and ice. 1. Detailed Description of the corrective	3/16/23

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K 211	Continued From page 3 On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation that the 2nd Floor - South Lounge Exit from the structure exhibited coverage of snow and ice. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	action taken or planned to correct the deficiency a. All vegetation preventing proper egress has been removed b. Swing gate has been removed c. Snow and ice has been removed 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. Snow removal company has been contacted and will start clearing emergency exits during snowfall b. In house personnel will monitor emergency exits for proper egress after all snowfalls 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. Emergency exits will be monitored during all snowfalls b. All emergency exits will be inspected throughout year during first and second shift fire drills to monitor proper egress 4. Identify who is responsible for the corrective actions and monitoring compliance a. Director of Environmental Services and/or designee 5. The actual or proposed date for completion of the remedy a. 03/20/23	
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	K 291		3/16/23

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K 291	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test operability of emergency lighting devices in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed during a review of available documentation that no documentation was presented for review associated to the 30 second monthly and 90 min annual testing of emergency lighting devices An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	K291 Emergency Lighting - testing Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed during a review of available documentation that no documentation was presented for review associated to the 30 second monthly and 90 min annual testing of emergency lighting devices. 1. Detailed Description of the corrective action taken or planned to correct the deficiency a. Identified all battery powered emergency lighting locations b. Completed first month 30 second test on each battery powered emergency light c. Location map created to ensure all devices are being checked during visual inspections 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. TELS monthly reminder for 30 second monthly testing b. TELS annual reminder for 1 ½ hour battery powered emergency lighting test 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. Written tracking sheet to ensure monthly and annual visual inspections are completed b. Monthly audits x3 to ensure testing has been completed. 4. Identify who is responsible for the corrective actions and monitoring compliance	

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K 291	Continued From page 5	K 291	a. Director of Environmental Services and/or designee 5. The actual or proposed date for completion of the remedy a. 03/20/23	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to identify an exit in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1 and 7.10.1.2.1. This deficient finding could have a pattenred impact on the residents within the facility. Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation that at the 2nd Floor - South Lounge corridor exit, that the door located in the protected stairwell was not marked or readily identifiable as the means of egress. Those descending from the 4th and 3rd Floors would encounter the same, having no visual indicator(s), and it would be unclear as to which door was the means of egress from the structure.	K 293	K293 Exit signage Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation that at the 2nd Floor - South Lounge corridor exit, that the door located in the protected stairwell was not marked or readily identifiable as the means of egress. Those descending from the 4th and 3rd Floors would encounter the same, having no visual indicator(s), and it would be unclear as to which door was the means of egress from the structure. An interview with the Maintenance Director verified this deficient finding at the time of discovery. 1. Detailed Description of the corrective action taken or planned to correct the deficiency	3/16/23

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 293	Continued From page 6 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 293	a. Lighted exit sign has been ordered, will be installed upon product arrival. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. Visual inspection will be done to ensure all exit signs are present. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. TELS work order for annual visual inspection of exit signage 4. Identify who is responsible for the corrective actions and monitoring compliance a. Director of Environmental Services and/or designee 5. The actual or proposed date for completion of the remedy a. 03/20/23	
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 and maintain initiating devices of fire alarm system in accordance with NFPA 101 (2012	K 345	K345 Fire alarm system - sensitivity testing Findings include: On 02/14/2023 between 0900 AM and	3/16/23

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 345	Continued From page 7 edition), Life Safety Code, sections 9.6.1.5, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 14.4.5.3 through 14.4.5.3.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed during a review of available documentation that no documentation was presented for review associated to fire alarm sensitivity testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	0300 PM, it was revealed during a review of available documentation that no documentation was presented for review associated to fire alarm sensitivity testing. Detailed Description of the corrective action taken or planned to correct the deficiency a. Nardini fire equipment has provided sensitivity testing report that was conducted on 12/13/2022 Address the measures that will be put in place to ensure the deficiency does not reoccur a. Sensitivity test report has been put into Life Safety Manual Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. TELS work order for biennial sensitivity testing Identify who is responsible for the corrective actions and monitoring compliance a. Director of Environmental Services and/or designee The actual or proposed date for completion of the remedy a. 03/20/23	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		3/16/23

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 _____	**02/14/2023**

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 355	Continued From page 8 by: Based on a review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 7.2.4.3 through 7.2.4.5, and 7.3.1.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed during a review of available documentation that no annual inspection and maintenance records were available for review 2. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that fire extinguisher tags throughout the facility were improperly completed, not capturing date of inspection and initials of individual performing the inspection 3. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, the fire extinguishers located in the 4th Floor South Lounge Area, the 3rd Floor South Wing Area, and the 1st Floor Boiler Room Area were last inspected in November of 2022 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	K355 Portable Fire Extinguishers Findings include: 1. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed during a review of available documentation that no annual inspection and maintenance records were available for review 2. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that fire extinguisher tags throughout the facility were improperly completed, not capturing date of inspection and initials of individual performing the inspection 3. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, the fire extinguishers located in the 4th Floor South Lounge Area, the 3rd Floor South Wing Area, and the 1st Floor Boiler Room Area were last inspected in November of 2022 Detailed Description of the corrective action taken or planned to correct the deficiency 1. Nardini fire equipment provided annual inspection report of fire extinguishers 2. In-service education on proper dating and initialing of fire extinguisher tags 3. Fire extinguishers located on 4th floor south lounge area, 3rd floor south wing area, and 1st floor boiler room were inspected. Address the measures that will be put in place to ensure the deficiency does not reoccur 1. Facility will have Nardini provide the annual inspection report. 2. Director of Environmental Services	

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 355	Continued From page 9	K 355	will do a monthly follow-up round for 3 months to ensure all fire extinguishers have been properly dated and initialed. 3. Director of Environmental services will ensure the fire extinguishers located in the 4th Floor South Lounge Area, the 3rd Floor South Wing Area, and the 1st Floor Boiler are inspected. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. Internal map locating all fire extinguishers will be created b. And a sign off sheet confirming all were checked during monthly inspection will be created. Identify who is responsible for the corrective actions and monitoring compliance a. Director of Environmental Services and/or designee The actual or proposed date for completion of the remedy a. 03/20/23	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including	K 541		3/16/23

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 541	Continued From page 10 pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4.4, 9.5.2, and NFPA 82 (2009 edition), section 5.2.3.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that the bio-hazard and laundry chutes located on the 4th, 3rd, and 2nd Floors of the facility, the chute doors did not self-close and properly latch upon testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 541	K541 Rubbish Chutes, Incinerators, Laundry Chutes Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that the biohazard and laundry chutes located on the 4th, 3rd, and 2nd Floors of the facility, the chute doors did not self-close and properly latch upon testing. Detailed Description of the corrective action taken or planned to correct the deficiency a. Parts for proper self closing and latching are being reviewed by BMSI, Building Material Supply Inc, engineering department are reviewing parts requirements b. Waiver requested Address the measures that will be put in place to ensure the deficiency does not reoccur a. Upon parts arrival trash and laundry chutes will be repaired	

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 541	Continued From page 11	K 541	Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. Director of Environmental Services or designee will do a monthly audits to ensure proper functioning of all laundry and trash chutes Identify who is responsible for the corrective actions and monitoring compliance Environmental Service Director and/or Designee The actual or proposed date for completion of the remedy a. 3/20/23	
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 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 available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1 and 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility.	K 712	K712 Fire Drills Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm	3/16/23

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K 712	Continued From page 12 Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the monthly fire drills are being completed. Last documented fire drill was conducted on 03/31/2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	that the monthly fire drills are being completed. Last documented fire drill was conducted on 03/31/2022. Detailed Description of the corrective action taken or planned to correct the deficiency a. Completed March 2023 fire drill b. Creation of proper documentation forms for fire drills c. Security company will provide Systems event report indicating tests were completed Address the measures that will be put in place to ensure the deficiency does not reoccur a. Monthly fire drill added to TELS that rotates between 1st, 2nd, and 3rd shifts Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. Safety committee will ensure monthly fire drills are completed. Identify who is responsible for the corrective actions and monitoring compliance a. Director of Environmental Services and/or designee The actual or proposed date for completion of the remedy a. 03/20/23	
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	K 761		3/16/23

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K 761	Continued From page 13 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 available documentation the facility failed to maintain, inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 7.2.1.15.2, and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that door inspections are being completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	K761 Doors - Testing Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that door inspections are being completed. Detailed Description of the corrective action taken or planned to correct the deficiency All required fire door assemblies have been inspected and tested using the 13-point door inspection Address the measures that will be put in place to ensure the deficiency does not reoccur List of all required fire door assemblies will be compiled and 13-point inspections will be cross referenced. Indicate how the facility plans to monitor future performance to ensure solutions are sustained TELS work order was created for all required fire door assembly's annual door inspection Identify who is responsible for the	

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K 761	Continued From page 14	K 761	corrective actions and monitoring compliance Director of Environmental Services or Designee The actual or proposed date for completion of the remedy 03/20/23	
K 914 SS=F	Electrical Systems - Maintenance and Testing 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 inspect and maintain electrical receptacles in resident rooms per NFPA 99 (2012 edition), Health Care	K 914	K914 Electrical Systems – outlet testing Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of	3/16/23

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 914	Continued From page 15 Facilities Code, section(s) 6.3.3.2, 6.3.4.1.3, 6.3.4.1.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that electrical outlet testing is being completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	available documentation, that no documentation was presented to confirm that electrical outlet testing is being completed. Detailed Description of the corrective action taken or planned to correct the deficiency Completed the annual electrical outlet testing. Address the measures that will be put in place to ensure the deficiency does not reoccur TELS work order for annual outlet testing was created Indicate how the facility plans to monitor future performance to ensure solutions are sustained Audit sheet labeling every room in facility completed to ensure all areas were checked to be in compliance. Visual inspections will be completed when work is being done in rooms to ensure no noticeable damage has occurred between annual inspections. Identify who is responsible for the corrective actions and monitoring compliance Director of Environmental Services or Designee The actual or proposed date for completion of the remedy 03/20/23	
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	K 918		3/16/23

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K 918	Continued From page 16 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 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 inspect and test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.3 and 6.5.4.1.1.2 and NFPA 110 (2010 edition) 8.4.1, 8.4.9, 8.4.9.2.	K 918	K918 Electrical Systems – generator inspections Findings include: 1. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no	

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K 918	Continued From page 17 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the weekly inspections of the emergency generator is being completed. 2. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that monthly inspections of the emergency generator is being completed. 3. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the required once every 36 months - 4 hour continuous run of the emergency generator is being completed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918	documentation was presented to confirm that the weekly inspections of the emergency generator is being completed. 2. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that monthly inspections of the emergency generator is being completed. 3. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the required once every 36 months - 4 hour continuous run of the emergency generator is being completed. Detailed Description of the corrective action taken or planned to correct the deficiency 1. Have obtained weekly inspection form for required testing and will start conducting weekly inspections on or before 04/15/23 2. Have obtained monthly inspection form for required testing and will start conducting monthly inspections on or before 04/15/23 3. Will schedule 36-month 4-hour continuous run on or before (Waiver date) Address the measures that will be put in place to ensure the deficiency does not reoccur 1. Weekly TELS task to remind ES director of required testing 2. Monthly TELS task to remind ES director of required testing 3. 36-month TELS task to remind ES director of required testing Indicate how the facility plans to monitor	

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 918	Continued From page 18	K 918	future performance to ensure solutions are sustained 1. ES director will review weekly log report to ensure completion 2. ES director will review monthly log report to ensure completion 3. Pioneer critical power and ES director will ensure 36-month 4-hour run is completed Identify who is responsible for the corrective actions and monitoring compliance Director of Environmental Services or Designee The actual or proposed date for completion of the remedy 03/20/23	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920		3/16/23

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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
K 920	Continued From page 19 Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of flexible cords and cables as-well-as listed and labeled equipment in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400-8 (1) and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that in the following locations extension cords were found in use: Room 112, 325, 442 2. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that in the following locations refrigerator(s) were connected to relocatable power taps: 4th Floor - Med Room; 3rd Floor - Room 302; 3rd Floor - South Office Lounge Office; 2nd Floor - Room 200 (2 to the same device); 2nd Floor Office - Room 219; 1st Floor Offices - Rooms 102, 105, 192. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	K920 Electrical Equipment – Power cords/Extension cords Findings include: 1. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that in the following locations extension cords were found in use: Room 112, 325, 442 2. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that in the following locations refrigerator(s) were connected to relocatable power taps: 4th Floor - Med Room; 3rd Floor - Room 302; 3rd Floor - South Office Lounge Office; 2nd Floor - Room 200 (2 to the same device); 2nd Floor Office - Room 219; 1st Floor Offices - Rooms 102, 105, 192. Detailed Description of the corrective action taken or planned to correct the deficiency 1. Extension cords were removed from rooms 112, 325, 442 2. Refrigerators in the following rooms were either properly plugged in directly to wall, or removed 4th floor med room, room 302, 3rd floor south office lounge office, room 200 x2, room 219, room 102, 105, 192 Address the measures that will be put in place to ensure the deficiency does not	

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 _____	**02/14/2023**

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 920	Continued From page 20	K 920	reoccur 1. In service education to ensure staff know extension cords are not allowed in facility. 2. Re-education that all refrigerators must be directly plugged into wall. Indicate how the facility plans to monitor future performance to ensure solutions are sustained 1. Visual inspections to ensure extension cords are not in use in facility will be completed monthly for 3 months. 2. Visual inspections to ensure refrigerators are properly plugged in will be completed monthly for 3 months. Identify who is responsible for the corrective actions and monitoring compliance Director of Environmental Services or Designee The actual or proposed date for completion of the remedy 03/20/23	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		3/16/23

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 _____	**02/14/2023**

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K 923	Continued From page 21 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that in the Med Gas Storage Room (Room 129), there was mixed storage of empty/full cylinders.	K 923	K923 Gas Equipment – Cylinder and container storage Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that in the Med Gas Storage Room (Room 129), there was mixed storage of empty/full cylinders. Detailed Description of the corrective action taken or planned to correct the deficiency Cylinders were properly separated. New tape and signage placed to clearly	

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 _____	**02/14/2023**

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K 923	Continued From page 22 An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923	mark full and empty storage areas. Requested more tank holders so tanks coud be secured. Address the measures that will be put in place to ensure the deficiency does not reoccur Educate maintenance and nursing on new signage and storage areas. Indicate how the facility plans to monitor future performance to ensure solutions are sustained Weekly inspection for 3 months to ensure cylinders are being stored in proper areas. Identify who is responsible for the corrective actions and monitoring compliance Director of Environmental Services or Designee The actual or proposed date for completion of the remedy 3/20/23	

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K541	On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by observation, that the biohazard and laundry chutes located on the 4th, 3rd, and 2nd Floors of the facility, the chute doors did not self-close and properly latch upon testing. All parts for proper self closing and latching are on order, but parts may not arrive for some time due to supply chain issues. Once parts arrive all identified rubbish chutes, incinerators, laundry chutes will be fixed per regulation. A waiver will not impact the patients or residents due to the chutes being behind closed doors and not accessible to residents. A waiver is requested for 90 days with an estimated completion date of June 20, 2023

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* William Abderhalden 37009	Title State Fire Safety Supervisor	Office Minnesota State Fire Marshal Division	Date 03/16/2023

trash chute Serenity Humboldt

Steven Thomson <sthomson@bmsizone.com>

Thu 3/16/2023 9:52 AM

To: Jim Higgins <Jim.Higgins@benedictineliving.org>

Hello Jim, I have received your pictures from Bob. I have sent them to the manufacturer.

They are waiting for a review from their engineering department.

As soon as I received a response I will let you know.

Thank you

BMSI
BUILDING MATERIAL SUPPLY INC.

Follow @BMSIZONE

Specialty Products Division www.bmsizone.com

Steve Thomson
Building Material Supply Inc.
Project Coordinator
4555 West 77th St
Edina, MN 55435
P-763-252-5555 ext 135
F-763) 252-5552
sthomson@bmsizone.com
www.bmsizone.com

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Trash & Biohazard Chutes Audit

Month:_____

Date	# of Trash/Biohazard Chutes checked	Trash/Biohazard Chutes Close Properly Y/N	Issues Noted During Inspection	Notes
	2nd Floor: 3rd Floor: TCU:	2nd Floor: 3rd Floor: TCU:	2nd Floor: 3rd Floor: TCU:	
	2nd Floor: 3rd Floor: TCU:	2nd Floor: 3rd Floor: TCU:	2nd Floor: 3rd Floor: TCU:	

Audit all trash & biohazard chutes for proper closure biweekly x 1 month and then monthly x 3 months

Audits may continue based on QAPI determination

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K918	Findings include: On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the weekly inspections of the emergency generator is being completed. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that monthly inspections of the emergency generator is being completed. On 02/14/2023 between 0900 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the required once every 36 months - 4 hour continuous run of the emergency generator is being completed. Upon testing of the generator it was found that specific parts needed to be ordered to fix the generator. Cerenity Humboldt is currently on a backup generator until the facility generator can be fixed. Per Pioneer Critical Power, parts were ordered but no time frame as to when the parts will arrive due to supply chain issues. As soon as parts arrive, Pioneer Critial Power will fix the facility generator and run the proper load bank tests to comply with Life Safety Code and Health Code Regulations. A waiver is requested for 90 days with an estimated completion date of June 20, 2023

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* William Abderhalden 37009	Title State Fire Safety Supervisor	Office Minnesota State Fire Marshal Division	Date 03/16/2023

Generator Weekly Inspection Report

Facility: Crestview Senior Care 512 Generator Number: 1 of 1

Mark 'P' for Pass, or 'F' for Fail

Date		3-02	3-09	3-16					
Fuel	**Main Supply Level**	YES	P	P					
	Day Tank Level	N/A	P	P					
	Day Tank Float Switch	N/A	P	P					
	Transfer Pump Operation	N/A	P	P					
	Solenoid Valve Operation	N/A	P	P					
	System Clear of Water	Yes	P	P					
	Flexible Hoses & Connectors	P	P	P					
Engine	**Oil Level**	P	P	P					
	Oil Heater	P	P	P					
	General Inspection	P	P	P					
Cooling System	**Coolant level**	P	P	P					
	Heat Exchanger Cooling Water	P	P	P					
	Air Flow Through Radiator	P	P	P					
	Water Pumps	P	P	P					
	Flexible Hoses & Connectors	P	P	P					
	Jacket Water Heater	P	P	P					
Exhaust System	**Leakage**	P	P	P					
	Drain Condensate Trap	P	P	P					
Battery Electrolyte Level		P	P	P					
Electrical System		P	P	P					
General Housekeeping of Service Room		P	P	P					
Technician's Name		JR	JR	JR					
Technician's Signature									

Inspection conducted in accordance with NFPA 110-2010

Re: 512 Generator - update

Frank Robinson <frank.robinson@benedictineliving.org>

Tue 3/14/2023 11:22 AM

To: Joseph Ruza <joseph.ruza@benedictineliving.org>;Erika Streit <erika.streit@benedictineliving.org>

Sounds like a good plan. Thank you Joe.

Frank C. Robinson, LNHA, LALD | Executive Director
Cerenity Senior Care | Humboldt
512 Humboldt Avenue | St. Paul, MN 55107
Main: 651.220.1700
Direct: 651.220.1718
Fax: 651.220.1724
www.cerenityseniorcare.org

Cerenity SENIOR CARE
Humboldt

From: Joseph Ruza <joseph.ruza@benedictineliving.org>
Sent: Tuesday, March 14, 2023 11:20 AM
To: Frank Robinson <frank.robinson@benedictineliving.org>; Erika Streit <erika.streit@benedictineliving.org>
Subject: 512 Generator - update

I spoke with Pioneer Critical Power this morning and they said they are hoping to get the part in this week and will call to schedule right away, I will keep you informed as I learn more. Plan will be to repair our unit, run tests to ensure its fixed, then schedule the 4HR loadbank required for life safety

512 Generator - EMS Repair Quote

Joseph Ruza <joseph.ruza@benedictineliving.org>

Mon 2/27/2023 1:46 PM

To: Frank Robinson <frank.robinson@benedictineliving.org>

Cc: Erika Streit <erika.streit@benedictineliving.org>

Hi Frank & Erika, I've attached the repair quote to get our generator back operational. This includes a 2HR Loadbank test, this is Pioneer's internal process to ensure the repair is sufficient and holds load. This however, does NOT meet the Life Safety requirement of our 4HR Loadbank test, so how this will work is they will replace the controller, run the 2HR test, once that passes our generator is "fixed". Once fixed I will work with the scheduler to get our required 4HR test completed.

We have the temp generator in place, but the faster we can get this signed & approved the quicker they can order what's needed and get us scheduled.

Call if you have any questions

Thank you!

RE: Generator repair service for Cerenity Senior Care

Kellie Miller <kmiller@pioneercriticalpower.com>

Thu 3/16/2023 1:43 PM

To: Joseph Ruza <joseph.ruza@benedictineliving.org>;Erika Streit <erika.streit@benedictineliving.org>;Frank Robinson <frank.robinson@benedictineliving.org>

Thank you

Have a nice day,

Thank you,
Kellie Miller
Schedule Coordinator
Pioneer Critical Power
Direct (952)-512-2488
888-838-4043 (24/7 Emergency Service)

From: Joseph Ruza <joseph.ruza@benedictineliving.org>
Sent: Thursday, March 16, 2023 1:42 PM
To: Kellie Miller <kmiller@pioneercriticalpower.com>; Erika Streit <erika.streit@benedictineliving.org>; Frank Robinson <frank.robinson@benedictineliving.org>
Subject: Re: Generator repair service for Cerenity Senior Care

Hi, Tuesday works great! I will be POC, my number is 651-304-0247

Thank you!

From: Kellie Miller <kmiller@pioneercriticalpower.com>
Sent: Thursday, March 16, 2023 10:04 AM
To: Joseph Ruza <joseph.ruza@benedictineliving.org>
Subject: Generator repair service for Cerenity Senior Care

EXTERNAL SENDER: Please use caution...

Good Morning,

Looks like the parts will be in by Monday so I would like to schedule the repair for Tuesday 3.21.23 in the am. All I will need is who will be the point of contact and a phone number. I hope this day will work for you.

Once the repair is finished, I will get the Annual load Bank scheduled.

Thank You,

Kellie Miller
Account Manager/ Schedule Coordinator
Pioneer Critical Power
8900 109th Ave N
Ste. 800
Champlin, MN 55316
952-512-2488 Direct-Office Number
888-838-4043 (24/7 Emergency Service)

PIONEER