Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2023

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

RE: CCN: 245255
Cycle Start Date: November 30, 2023

Dear Administrator:

On November 30, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 1, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 30, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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 11/30/2023

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 11/27/23 - 11/30/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/27/23 - 11/30/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was 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 deficiencies cited: H52557214C (MN97299, MN97298, and MN97297), H52557215C (MN93546), H52557216C (MN97185), H52557524C (MN98719), and H52557467C (MN98836). 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. 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	F 000		

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

Electronically Signed | 12/21/2023

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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F 000	Continued From page 1 regulations has been attained.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		1/15/24

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F 690	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure catheter drainage bags were properly cleaned and stored in accordance with professional standards of practice for 1 of 1 resident (R38) reviewed for catheters. Findings include: The Center for Disease Control (CDC) Catheter-Associated Urinary Tract Infections (CAUTI) guideline dated 11/5/2015, identified after aseptic insertion of the urinary catheter, a closed drainage system should be maintained. If the aseptic technique was broken, disconnected, or if leakage occurred, the catheter and collecting system should be replaced with aseptic technique and sterile equipment used. R38's annual Minimum Data Set (MDS) dated 9/11/23, identified moderately impaired cognition and diagnoses of chronic kidney disease and urinary retention. R38 had an indwelling catheter and required extensive assist with toileting. R38's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 9/11/23, identified the CAA triggered due to usage of Foley catheter for urinary retention. R38 required extensive assist of two staff for toileting, was at risk for urinary infection and directed to continue to care plan. R38's care plan dated 2/29/23, identified a urinary catheter was used related to urinary retention, history of urinary tract infection (UTI) and cystitis. Interventions included: maintain a closed, sterile	F 690	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. The policy for cleaning and storage of catheter bags was reviewed and remains current. All nursing staff will be reeducated on the policy and procedure for cleaning and storage of catheter bags. R38's catheter bag was replaced, no signs/symptoms of UTI. Care plan has been reviewed and updated. Audits will be performed to identify all other residents with a foley catheter, and their care plans have been reviewed and updated. Audits of the cleaning and storage of catheter bags will be performed by the DON or their designee weekly for one month then monthly until substantial compliance is achieved. Results of audits will be reviewed at QAPI.	

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F 690	Continued From page 3 system with tubing free of kinks. The care plan lacked interventions related to breaking the closed system with a catheter leg bag for drainage. R38's orders dated 7/25/23, identified the foley catheter was to be changed on the eighth day of every month, size 16 FR (French) 10 milliliter (ml) balloon. The orders lacked instructions for management of the drainage bags. During an observation on 11/27/23 at 5:35 p.m., nursing assistant (NA)-A removed R38's leg bag from the catheter, cleaned the overnight drainage bag port with an alcohol wipe and attached to the catheter. NA-A brought the leg bag into the bathroom and drained it of 525 ml of urine. NA-A rinsed out the leg bag with water from the sink tap, placed the leg bag in a plastic clear garbage bag and placed the contents in the bathroom cabinet. During an interview on 11/27/23 at 5:45 p.m., NA-A stated the facility process was to rinse out catheter drainage bags with plain water. NA-A was not sure how often the catheter bags were changed to a new one. During an interview on 11/27/23 at 6:15 p.m., R38 stated she had no recent history of urinary tract infections and was unsure what the nursing assistants used to clean the catheter drainage bags. R38 stated the nurse replaced catheter and bags monthly. During an observation and interview on 11/29/23 at 7:06 a.m., R38's room had a strong urine odor. Upon entering the room, NA-B stated he finished switching R38's catheter bag to the leg bag. NA-B	F 690		

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F 690	Continued From page 4 stated he cleaned the the catheter ports with alcohol wipes and rinsed out the drainage bag with water from the sink. NA-B then showed the surveyor how the drainage bag was placed in a plastic garbage bag and stored in the bathroom cabinet. During an interview on 11/29/23 at 7:11 a.m., NA-C stated the facility process was to clean catheter connection ports with alcohol wipes and rinse the drainage bag with water, place the drainage bag in a plastic bag and put it in the bathroom cabinet. During an interview on 11/29/23 at 07:12 p.m., licensed practical nurse (LPN)-A stated he was unsure of the process to clean and store drainage bags bags. LPN-A stated drainage bags were changed based on the provider order for catheter changes. During an interview on 11/29/23 at 7:13 a.m., registered nurse (RN)-A stated he was unsure of the process to clean and store drainage bags. LPN-A stated drainage bags were changed based on the provider order for catheter changes. During an interview on 11/29/23 at 7:18 a.m., RN-B stated she was unsure of the process to clean and store drainage bags but would find out. During a follow up interview on 11/29/23 at 7:45 a.m., RN-B stated staff were taught to rinse drainage bags out with water and hang to dry. RN-B went to R38's room to see how the catheter bag was stored. RN-B acknowledged a urine odor near the bathroom cabinet where the drainage bag was stored, and she stated she was unsure if storing the drainage bags inside a plastic bag in	F 690		

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F 690	Continued From page 5 the cabinet was acceptable. During an interview on 11/29/23 at 12:12 p.m., the director of nursing (DON) stated she expected staff to follow the policy for cleaning and storage of catheter drainage bags. The DON provided the facility policy titled Prevention of CAUTI dated 2017. The policy identified a sterile, closed, gravity based system was used and to avoid breaking the closed system. The policy lacked direction for when the closed system was broken for the use of a leg bag. The DON then stated she would expect staff to rinse the catheter out with water, pat dry and put into a clean storage area. The DON stated she would not expect staff to put the wet catheter drainage bags into another plastic bag. During an interview on 11/29/23 at 1:12 p.m., the heath information tech (HIT) identified the following two catheter drainage bag systems which were used in the facility: Advantage urinary drainage bag #4270 and Rusch leg bag #453932. During an interview on 11/29/23 at 1:20 p.m., the Advantage catheter support representative (SR)-A stated she could not find cleaning or storage instructions for the drainage bags and would consult with their quality department and return with emailed information. Email correspondence from SR-A dated 11/29/23 at 2:11 p.m., identified the catheter bag should not have been cleaned or re-used once it was broken apart from the closed system. During an interview on 11/29/23 at 2:27 p.m., the Rusch catheter support representative (SR)-B stated there were no instructions on the catheter	F 690		

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F 690	Continued From page 6 package for cleaning or reuse because, in accordance with the CDC, catheters should not be broken apart from their closed system, which was not always realistic, and in that case the manufacturer recommended 3/4 cup warm water and 1/4 cup plain vinegar mixture for cleaning and rinsing the catheter drainage bags as an infection control measure. The facility policy provided on 11/30/23, titled Cleaning Foley Catheter Leg Bags dated 2018, identified a closed urinary drainage system was typical, however, if broken for use of a smaller size leg bag, the leg bag would be aseptically maintained. Cleaning the interior of the leg bag identified diluted vinegar (one part vinegar to three parts water) had bactericidal properties and should be used to clean the catheter bags. The catheter bags and caps should be allowed to air dry with placement upright.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		1/15/24

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F 758	Continued From page 7 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor a resident (R59) with involuntary muscle movements who was taking antipsychotic medications. R59's quarterly Minimum Data Set (MDS) dated	F 758	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	

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F 758	Continued From page 8 9/28/23, indicated moderately impaired cognition and diagnoses of alzheimer's disease (early onset), dementia with other behavioral disturbance and adjustment disorder with anxiety. It further indicated R59 required total dependence with transfers, required extensive assistance with all other activities of daily living (ADL), and received an antipsychotic 7 out of 7 days in the look back period. R59's physician's orders dated 11/03/22, indicated quetiapine tablet 50 milligrams by mouth, three times a day (8:00 a.m., 12:00 p.m., 7:00 p.m.) for agitation. R59's care plan dated 9/29/22 indicated R59 received a psychotropic medication with interventions to administer medication per medical doctors order, monitor for target behaviors daily, monthly medication record review by pharmacist, and observe and report efficacy of medication use. It did not indicate to monitor for adverse reactions or side effects of the medication. R59's abnormal involunary movement scale (AIMS) dated 6/28/23, indicated R59 did not have any involuntary movments including jaw biting, clenching, and/or chewing. During observation on 11/27/23 at 5:32 p.m., R59 was sitting in her room and her mouth was moving in a chewing motion. During observation and interview on 11/29/23 at 7:21 a.m., nursing assistant (NA)-E verified R59's mouth was moving in a chewing motion and stated it had been that way since she started working at the facility.	F 758	the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. The policy on psychotropic drug use and the AIMS policy was reviewed and remains current. All licensed nursing staff will be reeducated on psychotropic drug policy and procedure and the AIMS policy. R59's care plan has been reviewed and updated, a new AIMS was completed and provider was notified. An audit to identify all other residents taking antipsychotic medications has been performed and care plans will be reviewed and updated if necessary and new AIMS completed. Audits of residents on antipsychotic medications will be performed by DON or designee weekly for one month then monthly until substantial compliance is achieved. Results of audits will be reviewed at QAPI.	

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F 758	Continued From page 9 During observation and interview on 11/29/23 at 7:27 a.m., NA-F verified R59's mouth was moving in a chewing motion and stated it had been that way for a long time. During an interview on 11/30/23 at 9:04 a.m., RN-C stated observed R59's mouth moving in a chewing motion and should complete an AIMS if a resident had symptoms/side effects to an antipsychotic medication. During an interview on 11/30/23 at 9:11 a.m., RN-D stated nurses were responsible for completing an AIMS every 6 months and if a resident began having abnormal muscle movements while receiving an antispychotic medication. During interview on 11/30/23 at 9:24 a.m. the clinical manager stated the nurses were responsible for completing an AIMS for residents taking an antipsychotic medication on admission and then every 6 months. The clinical manager also stated an AIMS should be completed if a resident started to have symptoms along with notifying the provider and family. During interview on 11/30/23 at 10:50 a.m., the director of nursing (DON) stated the nurses were responsible for completing an AIMS assessment every 6 months and if the resident started to have symptoms/adverse effects to an antipsychotic medication. The facility's policy on AIMS dated 9/7/17, indicated residents will be examined for potential side effects from psychotropic medication use. The Abnormal Involuntary Movements Scale	F 758		

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 11/30/2023

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 758	Continued From page 10 (AIMS) in the electronic health record will be used to assist in identification of tardive dyskinesia (TD) side effects. Residents that are prescribed antipsychotics shall be regularly and systematically assessed and evaluated for tardive dyskinesia (TD).	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 kitchenettes were cleaned,including the cleaning of the kitchenette refrigerators and also failed to monitor refrigerator temperatures daily to maintain food safety. This had the potential to affect all residents who resided at the facility.	F 812	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	1/15/24

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F 812	Continued From page 11 Findings Include: During observation and record review on 11/30/23 at 9:34 a.m., the second-floor kitchenette countertop was noted with debris and dust buildup. The refrigerator freezer had spilled brownish matter frozen to the bottom lining of the freezer. The refrigerator had brown buildup and dark brownish stains in the refrigerator shelving and door compartments. During record review, the refrigerator temp log on the door of the refrigerator was dated 5/23 and was missing several days of documented temperature checks for May 2023. Only the following temperatures were documented: -5/2/23-temperature was recorded as 36 degrees Celsius -5/8/23-temperature was recorded as 36 degrees Celsius -5/16/23-temperature was recorded as 36 degrees Celsius -5/18/23-temperature was recorded as 18 degrees Celsius All other dates for 5/23 temperature logs were missing temperature documentation. During interview on 11/30/23 at 9:34 a.m., second-floor clinical nurse manager, licensed practical nurse (LPN)-B stated the kitchen staff were responsible to monitor the temperatures of the refrigerators and also were responsible for the cleaning of the refrigerators and should be monitored daily. LPN-B verified the counters, refrigerator and freezer were dirty and needed to be cleaned. During observation and interview on 11/30/23 at	F 812	accordance with federal and state law requirements. The culinary department sanitation policy and procedure has been reviewed and remains current. All dietary and housekeeping staff have been reeducated on the culinary department sanitation policy and procedure and temperature logs. All kitchenettes have been cleaned and temperature logs are in place. The dietary manager or their designee will perform weekly audits on the sanitation of kitchenettes for one month and then monthly until substantial compliance is achieved and audit fridge temperatures 5 times per week for 2 weeks then twice per week until substantial compliance is achieved. Results will be reviewed at QAPI.	

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F 812	Continued From page 12 9:51 a.m., the third-floor kitchenette, was noted with debris on the countertop, and had dust build up. There was a brownish yellow stained towel under the coffee machine. The outside of the refrigerator had brown and white stains. The inside of the freezer and refrigerator also had brownish buildup and dark stains in the refrigerator shelving and door compartments. There was one uncovered cup of frozen undated content in a container in the freezer door. Clinical nurse manager, registered nurse (RN)-B verified the refrigerator was dirty and needed to be cleaned. During observation and interview on 11/30/23 at 10:00 a.m., the fourth-floor kitchenette was noted with debris on the countertop, and had dust build up. The outside of the refrigerator had dirt stains. The inside of the freezer and refrigerator also had brown buildup and dark brown stains in the refrigerator shelving and door compartments. The refrigerator had ice buildup at the bottom of the shelves. Several of the contents in the nutritional supplements in the refrigerators had brownish sticky stains and there was caked dirt on the refrigerator shelving. There were also several expired items in the refrigerator: -one box of Ensure with an expiration date of 9/23 -one box of Osmolite with an expiration date of 4/23 During interview on 11/30/23 at 10:00 a.m., Clinical nurse manager RN-E verified the refrigerator had dirt buildup and dirt stains and needed to be cleaned and verified the expired Ensure and Osmilite. Temperature monitoring logs for current and previous months were requested but not provided	F 812		

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F 812	Continued From page 13 for second and third floor. Cleaning logs for refrigerators were requested and not provided. During interview on 11/30/23 at 12:09 p.m., dietary manager (DM) stated the staff had checked on the kitchenettes but was unaware the kitchen staff were responsible to check the refrigerator temperatures. DM stated the understanding was housekeeping was doing the cleaning of the refrigerators since the dietary staff were in another building. The dietary staff took out old snacks and food out of the refrigerators when replacement was brought up but the staff were not involved with cleaning of the refrigerator and temperature monitoring. The facility Culinary Department Sanitation Monitoring policy updated 2019, indicated there will be a comprehensive system for on-going sanitation inspections of the work environment in the Culinary Department. The Culinary Services Director is responsible for monitoring the Culinary Department on a regular basis to assure the department is operated and maintained in a sanitary manner. The Culinary Services Director/designee will accomplish comprehensive sanitation inspections on a monthly basis using the Sanitation Checklist. During state window Food Service Observation form will be completed as necessary or at least monthly. Areas included in the inspections will include at least the following:Storage Areas,Refrigerator/Freezer Units, Equipment/Utensils, Food Preparation Area(s)Dishwashing Area Kitchenette Serving Area(s) outside the main kitchen	F 812		

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2023**

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 recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/01/2023. At the time of this survey, Cerenity Senior Care On Humbolt was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2023

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
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K 000	Continued From page 1 IS NOT REQUIRED. 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. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. The building is fully sprinklered. The facility has a	K 000		

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K 000	Continued From page 2 fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. Because the original building and the addition meet the construction type allowed for existing buildings, it was surveyed as one building. The facility has a capacity of 93 beds and had a census of 81 at the time of the survey.	K 000		
K 353 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		12/18/23

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K 353	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler gauges per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25 (2011 edition), section 5.3.2.1. This deficient findings could have a isolated impact on the residents within the facility. Findings include: On 12/01/2023 at 10:30 AM, it was revealed by observation that several gauges on the fire sprinkler system that exceed the 5 year of service. Most of the gauges were installed in 2018 and should have been replaced during the annual inspection on 04/20/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	K353 1. All outdated gauges were replaced 2. TELS task was added to ensure compliance. 3. Maintenance director will monitor TELS tasks to ensure continued compliance. 4. Maintenance director. 5. 12/18/23	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 7R2O11

Dear Administrator:

The above facility was surveyed on November 27, 2023 through November 30, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00538	A. BUILDING: _____ B. WING _____	C 11/30/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/27/23 - 11/30/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H52557214C (MN97299, MN97298, and MN97297), H52557215C (MN93546), H52557216C (MN97185), H52557524C (MN98719), and H52557467C (MN98836) and no licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure catheter	2 910	Corrected	1/15/24

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	00538	A. BUILDING: _____ B. WING _____	C 11/30/2023

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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2 910	Continued From page 3 drainage bags were properly cleaned and stored in accordance with professional standards of practice for 1 of 1 resident (R38) reviewed for catheters. Findings include: The Center for Disease Control (CDC) Catheter-Associated Urinary Tract Infections (CAUTI) guideline dated 11/5/2015, identified after aseptic insertion of the urinary catheter, a closed drainage system should be maintained. If the aseptic technique was broken, disconnected, or if leakage occurred, the catheter and collecting system should be replaced with aseptic technique and sterile equipment used. R38's annual Minimum Data Set (MDS) dated 9/11/23, identified moderately impaired cognition and diagnoses of chronic kidney disease and urinary retention. R38 had an indwelling catheter and required extensive assist with toileting. R38's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 9/11/23, identified the CAA triggered due to usage of Foley catheter for urinary retention. R38 required extensive assist of two staff for toileting, was at risk for urinary infection and directed to continue to care plan. R38's care plan dated 2/29/23, identified a urinary catheter was used related to urinary retention, history of urinary tract infection (UTI) and cystitis. Interventions included: maintain a closed, sterile system with tubing free of kinks. The care plan lacked interventions related to breaking the closed system with a catheter leg bag for drainage.	2 910		

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2 910	Continued From page 4 R38's orders dated 7/25/23, identified the foley catheter was to be changed on the eighth day of every month, size 16 FR (French) 10 milliliter (ml) balloon. The orders lacked instructions for management of the drainage bags. During an observation on 11/27/23 at 5:35 p.m., nursing assistant (NA)-A removed R38's leg bag from the catheter, cleaned the overnight drainage bag port with an alcohol wipe and attached to the catheter. NA-A brought the leg bag into the bathroom and drained it of 525 ml of urine. NA-A rinsed out the leg bag with water from the sink tap, placed the leg bag in a plastic clear garbage bag and placed the contents in the bathroom cabinet. During an interview on 11/27/23 at 5:45 p.m., NA-A stated the facility process was to rinse out catheter drainage bags with plain water. NA-A was not sure how often the catheter bags were changed to a new one. During an interview on 11/27/23 at 6:15 p.m., R38 stated she had no recent history of urinary tract infections and was unsure what the nursing assistants used to clean the catheter drainage bags. R38 stated the nurse replaced catheter and bags monthly. During an observation and interview on 11/29/23 at 7:06 a.m., R38's room had a strong urine odor. Upon entering the room, NA-B stated he finished switching R38's catheter bag to the leg bag. NA-B stated he cleaned the the catheter ports with alcohol wipes and rinsed out the drainage bag with water from the sink. NA-B then showed the surveyor how the drainage bag was placed in a plastic garbage bag and stored in the bathroom cabinet.	2 910		

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2 910	Continued From page 5 During an interview on 11/29/23 at 7:11 a.m., NA-C stated the facility process was to clean catheter connection ports with alcohol wipes and rinse the drainage bag with water, place the drainage bag in a plastic bag and put it in the bathroom cabinet. During an interview on 11/29/23 at 07:12 p.m., licensed practical nurse (LPN)-A stated he was unsure of the process to clean and store drainage bags bags. LPN-A stated drainage bags were changed based on the provider order for catheter changes. During an interview on 11/29/23 at 7:13 a.m., registered nurse (RN)-A stated he was unsure of the process to clean and store drainage bags. LPN-A stated drainage bags were changed based on the provider order for catheter changes. During an interview on 11/29/23 at 7:18 a.m., RN-B stated she was unsure of the process to clean and store drainage bags but would find out. During a follow up interview on 11/29/23 at 7:45 a.m., RN-B stated staff were taught to rinse drainage bags out with water and hang to dry. RN-B went to R38's room to see how the catheter bag was stored. RN-B acknowledged a urine odor near the bathroom cabinet where the drainage bag was stored, and she stated she was unsure if storing the drainage bags inside a plastic bag in the cabinet was acceptable. During an interview on 11/29/23 at 12:12 p.m., the director of nursing (DON) stated she expected staff to follow the policy for cleaning and storage of catheter drainage bags. The DON provided the facility policy titled Prevention of CAUTI dated	2 910		

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2 910	Continued From page 6 2017. The policy identified a sterile, closed, gravity based system was used and to avoid breaking the closed system. The policy lacked direction for when the closed system was broken for the use of a leg bag. The DON then stated she would expect staff to rinse the catheter out with water, pat dry and put into a clean storage area. The DON stated she would not expect staff to put the wet catheter drainage bags into another plastic bag. During an interview on 11/29/23 at 1:12 p.m., the heath information tech (HIT) identified the following two catheter drainage bag systems which were used in the facility: Advantage urinary drainage bag #4270 and Rusch leg bag #453932. During an interview on 11/29/23 at 1:20 p.m., the Advantage catheter support representative (SR)-A stated she could not find cleaning or storage instructions for the drainage bags and would consult with their quality department and return with emailed information. Email correspondence from SR-A dated 11/29/23 at 2:11 p.m., identified the catheter bag should not have been cleaned or re-used once it was broken apart from the closed system. During an interview on 11/29/23 at 2:27 p.m., the Rusch catheter support representative (SR)-B stated there were no instructions on the catheter package for cleaning or reuse because, in accordance with the CDC, catheters should not be broken apart from their closed system, which was not always realistic, and in that case the manufacturer recommended 3/4 cup warm water and 1/4 cup plain vinegar mixture for cleaning and rinsing the catheter drainage bags as an infection control measure.	2 910		

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2 910	Continued From page 7 The facility policy provided on 11/30/23, titled Cleaning Foley Catheter Leg Bags dated 2018, identified a closed urinary drainage system was typical, however, if broken for use of a smaller size leg bag, the leg bag would be aseptically maintained. Cleaning the interior of the leg bag identified diluted vinegar (one part vinegar to three parts water) had bactericidal properties and should be used to clean the catheter bags. The catheter bags and caps should be allowed to air dry with placement upright. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with catheters to ensure proper cleaning of leg bags are performed. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21105	MN Rule 4658.0650 Subp. 6 Food Supplies; Prohibited storage Subp. 6. Prohibited storage. The storage of detergents, cleaners, pesticides, and other nonfood items not related to the operation of the dietary service, including employees' personal items, is prohibited in food storage areas. The nursing home may store dry goods and paper products related to the dietary service in the food storage area.	21105		1/15/24

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21105	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 kitchenettes were cleaned,including the cleaning of the kitchenette refrigerators and also failed to monitor refrigerator temperatures daily to maintain food safety. This had the potential to affect all residents who resided at the facility. Findings Include: During observation and record review on 11/30/23 at 9:34 a.m., the second-floor kitchenette countertop was noted with debris and dust buildup. The refrigerator freezer had spilled brownish matter frozen to the bottom lining of the freezer. The refrigerator had brown buildup and dark brownish stains in the refrigerator shelving and door compartments. During record review, the refrigerator temp log on the door of the refrigerator was dated 5/23 and was missing several days of documented temperature checks for May 2023. Only the following temperatures were documented: -5/2/23-temperature was recorded as 36 degrees Celsius -5/8/23-temperature was recorded as 36 degrees Celsius -5/16/23-temperature was recorded as 36 degrees Celsius -5/18/23-temperature was recorded as 18 degrees Celsius All other dates for 5/23 temperature logs were missing temperature documentation. During interview on 11/30/23 at 9:34 a.m.,	21105	Corrected	

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21105	Continued From page 9 second-floor clinical nurse manager, licensed practical nurse (LPN)-B stated the kitchen staff were responsible to monitor the temperatures of the refrigerators and also were responsible for the cleaning of the refrigerators and should be monitored daily. LPN-B verified the counters, refrigerator and freezer were dirty and needed to be cleaned. During observation and interview on 11/30/23 at 9:51 a.m., the third-floor kitchenette, was noted with debris on the countertop, and had dust build up. There was a brownish yellow stained towel under the coffee machine. The outside of the refrigerator had brown and white stains. The inside of the freezer and refrigerator also had brownish buildup and dark stains in the refrigerator shelving and door compartments. There was one uncovered cup of frozen undated content in a container in the freezer door. Clinical nurse manager, registered nurse (RN)-B verified the refrigerator was dirty and needed to be cleaned. During observation and interview on 11/30/23 at 10:00 a.m., the fourth-floor kitchenette was noted with debris on the countertop, and had dust build up. The outside of the refrigerator had dirt stains. The inside of the freezer and refrigerator also had brown buildup and dark brown stains in the refrigerator shelving and door compartments. The refrigerator had ice buildup at the bottom of the shelves. Several of the contents in the nutritional supplements in the refrigerators had brownish sticky stains and there was caked dirt on the refrigerator shelving. There were also several expired items in the refrigerator: -one box of Ensure with an expiration date of 9/23 -one box of Osmolite with an expiration date of 4/23	21105		

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21105	Continued From page 10 During interview on 11/30/23 at 10:00 a.m., Clinical nurse manager RN-E verified the refrigerator had dirt buildup and dirt stains and needed to be cleaned and verified the expired Ensure and Osmilite. Temperature monitoring logs for current and previous months were requested but not provided for second and third floor. Cleaning logs for refrigerators were requested and not provided. During interview on 11/30/23 at 12:09 p.m., dietary manager (DM) stated the staff had checked on the kitchenettes but was unaware the kitchen staff were responsible to check the refrigerator temperatures. DM stated the understanding was housekeeping was doing the cleaning of the refrigerators since the dietary staff were in another building. The dietary staff took out old snacks and food out of the refrigerators when replacement was brought up but the staff were not involved with cleaning of the refrigerator and temperature monitoring. The facility Culinary Department Sanitation Monitoring policy updated 2019, indicated there will be a comprehensive system for on-going sanitation inspections of the work environment in the Culinary Department. The Culinary Services Director is responsible for monitoring the Culinary Department on a regular basis to assure the department is operated and maintained in a sanitary manner. The Culinary Services Director/designee will accomplish comprehensive sanitation inspections on a monthly basis using the Sanitation Checklist. During state window Food Service Observation form will be completed as necessary or at least monthly. Areas included in the inspections will include at least the	21105		

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21105	Continued From page 11 following:Storage Areas,Refrigerator/Freezer Units, Equipment/Utensils, Food Preparation Area(s)Dishwashing Area Kitchenette Serving Area(s) outside the main kitchen SUGGESTED METHOD OF CORRECTION: The culinary director, registered dietician, or designee could ensure foods are stored, labeled, and not expired, to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage, labeling, and monitoring for expired food. The culinary director, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored, labeled appropriately, and not expired. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21105		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 24, 2024

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

RE: CCN: 245255
Cycle Start Date: November 30, 2023

Dear Administrator:

On January 18, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 24, 2024

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

Re: Reinspection Results
Event ID: 7R2O12

Dear Administrator:

On January 18, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 30, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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