DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

REVISED

June 23, 2022

Administrator
Cerenity Residence On Humboldt
514 Humboldt Avenue
Saint Paul, MN 55107

RE: Project Number SL30462015

Dear Administrator:

On June 6, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the March 31, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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Electronically Delivered

April 27, 2022

Administrator
Cerenity Residence on Humboldt
514 Humboldt Avenue
Saint Paul, MN 55107

RE: Project Number(s) SL30462015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 31, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30462	A. BUILDING: _____ B. WING _____	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30462015 On March 29, 2022, through March 31, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 66 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. On March 30, 2022, at 2:55 p.m. an immediate correction order was written for 2310. On March 31, 2022, the immediacy of the 2310 order was removed, scope and level of noncompliance remain the same.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 29, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 2 (21) days	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 650		

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0 650	Continued From page 3 review, the licensee failed to ensure the employee record contained the required content for one of two unlicensed personnel (ULP)-D with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D's employee record lacked a current job description. ULP-D was hired on May 21, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On March 30, 2022, from 7:00 a.m. to 9:00 a.m., ULP-D was observed to provide medication administration and cares and services to include: application of compression stockings and blood sugar monitoring. On March 30, 2022, at 9:30 a.m., director of nursing (DON)-B verified ULP-D's employee record did not contain a current job description. The licensee's 2022 Personnel policy verified the employee record would include a current job description. No further information was provided.	0 650		

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0 650	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required smoke alarms outside the vicinity of sleeping rooms of resident apartments #126 and #336 and failed to provide interconnection of smoke alarms for the one-bedroom resident apartments as required by	0 780		

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0 780	Continued From page 5 Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 30, 2022, between the hours of 10:00 a.m. and 1:30 p.m., survey staff toured the 5-story facility with the director of maintenance (DOM)-E and the assisted living director (LALD)-A. At the start of the tour, survey staff inquired about the number of one- and/or two-bedroom apartments in the facility. The DOM-E stated that the facility consisted of mostly studio design types and a total of four one-bedroom apartments in the assisted living facility. MISSING SMOKE ALARMS -At approximately 11:30 p.m., staff toured the one-bedroom apartment #336 on the 3rd floor and observed there was no smoke alarm provided outside the vicinity of the sleeping room. The DOM-E and the LALD-A confirmed the missing smoke alarm. -At approximately 12:30 p.m., staff toured the one-bedroom apartment # 126 and observed there was no smoke alarm provided outside the vicinity of the sleeping room. The DOM-E and the LALD-A confirmed the missing smoke alarm. INTERCONNECTION of SMOKE ALARMS -From approximately 11:30 a.m. to 12:40 p.m.,	0 780		

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0 780	Continued From page 6 survey staff observed smoke alarms for the one-bedroom apartments #213 and #313 failed to sound both alarms in each apartment when tested by the DOM-E. Survey staff explained to the DOM-E and the LALD-A that all smoke alarms in the apartment must sound for notification throughout when one alarm sounds. -At approximately 11:30 a.m., survey staff explained that the interconnection of smoke alarms for #126 and #336 must be interconnected when those missing alarms are installed. At approximately 12:40 p.m., the DOM-E and the LALD-A confirmed the findings as the DOM-E stated that they will be ordering the new wireless battery smoke alarms that will be needed for the interconnection of the alarms to replace the existing battery-operated smoke alarms. On March 30, 2022, at approximately 3:30 p.m., DOM-E and the LALD-A acknowledged the above findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 30, 2022, between the hours of 10:00 a.m. and 1:30 p.m., survey staff toured the 5-story facility with the director of maintenance (DOM)-E and the assisted living director (LALD)-A. At approximately 10:10 a.m., survey staff asked to start the tour on the top floor of the facility. The LALD-A explained the top floor (4th) was previously used for transitional nursing care but those beds have been moved to a different building on campus, and currently, the entire 4th floor is not being used except for employee training. Survey staff explained to the DOM-E and the LALD-A that a walkthrough of the 4th was necessary since being part of the same building. During the tour, survey staff did observe the 4th floor of the facility was not being used for resident care, except for employee training and storage of furniture, bedding, and furnishings. The 3rd floor	0 800		

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0 800	Continued From page 8 consisted of the secured memory care unit with the other half being assisted living. DRY PLUMBING FIXTURE TRAPS ON 4th FLOOR At approximately 10:20 a.m., at the beginning of the tour starting on the 4th floor, survey staff and the LALD-A had inquired about an odor during the tour. The DOM-E answered that it was probably a sewer gas smell. While on tour of resident rooms 428, 437, and 440, survey staff observed plumbing traps of the plumbing fixtures (toilets) were completely dried out. Survey staff explained to the DOM-E and LALD-A that dried-out toilet plumbing traps also meant dried-out shower and lavatory traps in all resident rooms (with plumbing fixtures) on the 4th. Survey staff further added that the dried out plumbing traps create unsafe and health risks to residents, visitors, and employees over time by allowing sewer gas to enter the building environment affecting indoor air, and needed to assess the plumbing system on the 4th floor to prevent sewer gas from entering the building as well as managing the water supply to prevent legionella growth from stagnant water over the years. Survey staff discussed and recommended adopting a water management plan for the facility and/or seeking out a plumbing professional for proper abandonment and capping of the plumbing on the 4th floor. The DOM-E and the LALD-A confirmed the findings during the tour. RESIDENT BATHROOM - The exhaust fans in resident bathrooms #241, #235, and #202 were heavily layered with dust. Survey staff explained and recommended that exhaust fans in all resident bathrooms need to be cleaned regularly to minimize buildups of dust. -The exhaust fans in resident bathrooms #322	0 800		

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0 800	Continued From page 9 and #330 were not working properly when tested with toilet tissue or a piece of paper. -The bathroom of resident #331 was not properly maintained as survey staff observed the ceiling in room #331 consisted of spotty light brown stain, rust on shower rod as well as the fire sprinkler escutcheon inside the bathroom. On March 30, 2022, at approximately 3:30 p.m., DOM-E and the LALD-A acknowledged the above findings during the exit interview. The LALD-A stated that they will take care of regular flushing of the toilets (plumbing fixtures) and addressing the sewer gas. Survey staff also added that storage of furnitures and equipment should be minimized on the 4th floor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 10 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan. This has the potential to directly affect the safety of staff and all residents receiving care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 30, 2022, between the hours of 10:00 a.m. and 1:30 p.m., survey staff toured the	0 810		

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0 810	Continued From page 11 5-story facility with the director of maintenance (DOM)-E and the assisted living director (LALD)-A. On March 30, 2022, at approximately 1:30 p.m., survey staff received and reviewed the facility fire safety and evacuation plan and related documentation. -Documentation review indicated the fire safety and evacuation plan lacked procedures for addressing resident movement and evacuation that included unique resident-specific needs. Unique situations may be residents who are ambulatory or non-ambulatory such as wheelchair-bound, on walkers, bedridden, cognitive deficit, and needing assistance during a fire or similar emergency and must also be addressed in the plan documentation. -Documentation review indicated the fire safety and evacuation plan lacked fire protection procedures for residents. On March 30, 2022, at approximately 3:30 p.m., DOM-E and the LALD-A confirmed and acknowledged the above findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following:	01370		

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01370	Continued From page 12 (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01370		

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01370	Continued From page 13	01370		

review, the facility failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for one of two unlicensed personnel (ULP)-D with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:

ULP-D's employee record lacked documentation of training and competency testing.

ULP-D was hired on May 21, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

On March 30, 2022, from 7:00 a.m. to 9:00 a.m., ULP-D was observed to provide medication administration and cares and services to include: application of compression stockings and blood sugar monitoring.

ULP-D's employee file lacked documentation of training and competency evaluations for the following topics:
-documentation requirements for all services provided
-reports of changes in the resident's condition to the supervisor designated by the facility
-maintenance of a clean and safe environment
-appropriate and safe techniques in personal

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01370	Continued From page 14 hygiene and grooming, including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -training on the prevention of falls -standby assistance techniques and how to perform them -basic nutrition, meal preparation, food safety, and assistance with eating -reparation of modified diets as ordered by a licensed health professional -understanding appropriate boundaries between staff and residents and the resident's family; -awareness of commonly used health technology equipment and assistive devices. On March 30, 2022, at 9:30 a.m., director of nursing (DON)-B confirmed ULP-D's personnel file did not contain documentation ULP-D completed training and competency testing in all required areas. The licensee's 2022 Assisted Living Orientation-ULP Staff policy verified "newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	01380		

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01380	Continued From page 15 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for one of two unlicensed personnel (ULP)-D with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D's employee record lacked documentation of training and competency testing. ULP-D was hired on May 21, 2018, under the	01380		

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01380	Continued From page 16 comprehensive home care license and began providing assisted living services on August 1, 2021. On March 30, 2022, from 7:00 a.m. to 9:00 a.m., ULP-D was observed to provide medication administration and cares and services to include: application of compression stockings and blood sugar monitoring. ULP-D's employee file lacked documentation of training and competency evaluations for the following topics: -observing, reporting, and documenting resident status -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel -recognizing physical, emotional, cognitive, and developmental needs of the resident -safe transfer techniques and ambulation -range of motioning and positioning On March 30, 2022, at 9:30 a.m., director of nursing (DON)-B confirmed ULP-D's personnel file did not contain documentation ULP-D completed training and competency testing in all required areas. The licensee's 2022 Assisted Living Orientation-ULP Staff policy verified "newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		

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01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of two residents (R5 and R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). On March 30, 2022, at 7:50 a.m., observations of medication administration and a review of the locked medication cart on the assisted living unit was completed. The following was observed: R5's ProAir inhaler (bronchodilator) lacked a label which indicated the date the inhaler had been opened and when the inhaler would expire.	01890		

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01890	Continued From page 18 R5's Lumigan (treats glaucoma) 0.01% eye drops lacked a label which indicated the date the eye drops had been opened and when the eye drops would expire. The manufacturer's instructions for ProAir inhalers dated February 2019, instructed to dispose to albuterol inhalers 12 months after opening foil pouch. The manufacturer's instructions for Lumigan eye drops dated November 2021, instructed once a bottle is opened for use, to discard after six weeks. On March 30, 2022, at 9:45 a.m., a review of the locked medication cart on the dementia unit was completed. R4's Novolin 70/30 100 units/milliliters (ml) insulin pens (a multiple dose pen shaped injector device for insulin) lacked a label which indicated the date the insulin pen was opened or when the insulin pen expired. An unlicensed personnel (ULP-F) verified R2's insulin pen lacked a date when opened or the date of expiration. The manufacturer's instructions for Novolin single-patient use flex pen, dated November 2019, instructed users to dispose of the insulin 28 days after opening. On March 30, 2022, at 9:50 a.m., director of nursing (DON)-B stated the registered nurse (RN)-C monitors the medication carts weekly and ensures the carts have adequate medication supplies and ensures multiple use medications are dated. DON-B was unsure why the above medications were not dated. On March 30, 2022, at 10:00 a.m., a registered nurse (RN)-C stated staff was expected to date	01890		

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01890	Continued From page 19 all insulin pens when opened or with an expiration date. RN-C stated she monitored the medication carts on each floor on a weekly basis for expired medications and adequate supply. The Benedictine policy: Storage of Medications, copyright 2021, stated, "The RN will provide education to the to the client/client's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool place, a dry area, and according to manufacturer's guidelines." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01950		

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01950	Continued From page 20 in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for one of two employees (unlicensed personnel (ULP)-D) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D's employee record lacked documentation of training and competency testing of delegated tasks provided to licensee residents. ULP-D was hired on May 21, 2018, under the Comprehensive home care license and began providing assisted living services on August 1, 2021. On March 30, 2022, from 7:00 a.m. to 9:00 a.m. ULP-D was observed to provide medication administration and cares and services to include: application of compression stockings and blood sugar monitoring.	01950		

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01950	Continued From page 21 ULP-D's employee records lacked documentation of training and competency evaluation for compression stockings and blood sugar monitoring. On March 30, 2022, at 9:30 a.m. director of nursing (DON)-B confirmed ULP-D's record lacked documentation competency testing of delegated tasks provided to licensee residents to include compression stockings and blood sugar monitoring. The licensee's 2022 Competency Evaluations for Unlicensed Personnel policy verified the ULP's "will be trained to perform the task or procedure for each resident and will be able to demonstrate the ability to competently follow the procedures and perform the tasks." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for two of two residents (R2, R1) who utilized bed rails	02310		

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with records reviewed. This resulted in an immediate correction order on March 30, 2022, at 2:55 p.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On March 30, 2022, at 7:45 a.m. the director of nursing (DON)-B confirmed R2 had bed rails placed on her bed. The bed rails had not been assessed for safety, nor was education provided to the resident or representative on the risks and benefits for bed rail use. In addition, R1 had a u-shaped bedrail on the left side of her bed. DON-B stated the siderail measured greater than ten inches, however the side rail assessment completed January 26, 2022, lacked documentation of measurements.

R2 was admitted with diagnoses including dementia with behavioral disturbances and services to include medication administration, dressing and grooming, and toileting.

R1 was admitted with diagnoses including diabetes mellitus and hypertension. and services to include medication administration, dressing and grooming and blood sugar management.

On March 30, 2022, at 7:45 a.m. half bedrails were observed bilaterally at the head of R2' s

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bed. The rails were observed in the raised position. DON-B stated R2's record did not include the functional ability assessments indicating the presence of bedrails, or documentation of bedrail education of risks and benefits for bedrail use.

On March 30, 2022, at 8:00 a.m. a U-shaped bedrail was observed on the left side of R1's unoccupied bed. The bedrail was secure and not able to be lowered.

On March 30, 2022, at 9:30 a.m. DON-B stated R2 was admitted to hospice August 20, 2021, and a hospital bed with bedrails was provided. DON-B confirmed an assessment was not completed. DON-B provided a bedrail assessment dated 3/30/22, which included a safety assessment and measurements of the rails as follows: both rails measured 32 inches in length, 11 inches in height, and all openings between bars measured less than 4.5 inches. DON-B further verified specific measurements were not completed or documented for R1.

On March 30, 2022, at 9:35 a.m. DON-B was observed to measure R1's bedrail to be 17 inches wide and 7 inches high.

The Food and Drug Administration (FDA) "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep

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CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 24 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's undated Side Rails Policy "the RN [registered nurse] will assess and evaluate what the resident's needs are and assess to determine if the resident can safely utilize the siderail/equipment and determine whether the siderail/equipment meets the FDA [Food and Drug Administration] standards for siderails." No further information provided. TIME PERIOD FOR CORRECTION: Immediate On March 31, 2022, the immediacy of the 2310 order was removed, scope and level of noncompliance remain the same.	02310		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Follow-Up
Date: *04/07/22*
Time: 13:49:58
Report: 1023221075

Food and Beverage Establishment Inspection Report

Location:
Cerenity Residence On Humboldt
514 Humboldt Avenue
St Paul, MN55107
Ramsey County, 62

Establishment Info:
ID #: 0038376
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512201718
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders previously issued on 03/29/22 have NOT been corrected.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CFPM EMPLOYED AT THIS FACILITY. SENT INFORMATION ON FOOD MANAGER COURSE, TEST, AND APPLICATION WITH REPORT.

Issued on: 03/29/22 *Comply By: 03/29/22*

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

FIRST ISSUED 3/28/14 - VCT TILE FLOOR AND VINYL BASE COVE IN THE ROOM WITH THE WALK IN COOLER AND FREEZER NEEDS TO BE REPLACED WITH AN APPROVED FLOOR MATERIAL. REPLACE WHEN REPAIRS OR REMODELING IS NEEDED. REPEAT SINCE FIRST ISSUED.

Issued on: 03/29/22 *Comply By: 05/04/22*

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3 ** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

QUAT SOLUTION WAS CORRECT CONCENTRATION BUT WATER IS HOOKED UP TO COLD WATER LINE. SANITIZER WATER MUST BE AT LEAST 75dF.

Comply By: 04/07/22

Type: Follow-Up
Date: *04/07/22*
Time: 13:49:58
Report: 1023221075
Cerenity Residence On Humboldt

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at 62 Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: Yes

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/BURGER
Temperature: 173 Degrees Fahrenheit - Location: ON GRILL
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	2

REINSPECTION CONDUCTED TO ENSURE SAFE OPERATIONS AT THIS FACILITY. OPERATOR MUST CONTINUE TO TRAIN STAFF IN SAFE PROCEDURES AND MAINTAIN FACILITIES IN GOOD REPAIR. INSPECTION CONDUCTED WITH MARCELLE KIRK, FRANK ROBINSON, AND CHAD LIBERTY, THE PERSONS IN CHARGE.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023221075 of 04/07/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
MARCELLE KIRK
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us