Electronically Delivered

November 9, 2023

Licensee
Cerenity Residence - Marian
225 Frank Street
Saint Paul, MN  55106

RE: Project Number(s) SL21947015

Dear Licensee:

On October 27, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 23, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records.  It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

Electronically Delivered

September 21, 2023

Licensee
CERENITY RESIDENCE MARIAN OF ST. PAUL
225 Frank Street
Saint Paul, MN 55106

RE: Project Number(s) SL21947015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH 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.

**STATE CORRECTION ORDERS**

The enclosed State Form documents the state correction orders. The MDH 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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (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 survey:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

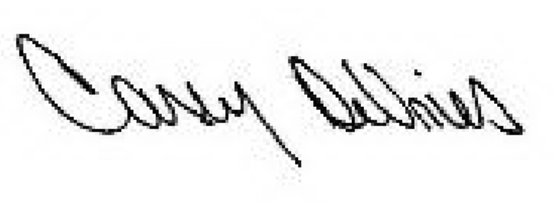
**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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<br><br>*****ATTENTION******<br><br>ASSISTED LIVING LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL21947015-0<br><br>On August 21, 2023, through August 23, 2023, 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 94 residents, 32 of whom received services under the provider's Assisted Living Facility.<br><br>An immediate correction order was identified on August 22, 2023, issued for SL21947015-0, tag identification 2310.<br><br>On August 23, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged. | 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 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 650 SS=F | 144G.42 Subd. 8 Employee records | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 0 650 | Continued From page 1<br><br>(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:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(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<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-H).<br><br>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 | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 0 650 | Continued From page 2<br>of the residents).<br><br>The findings include:<br><br>LPN-C<br>LPN-C was hired by the licensee on September 8, 2015, to provide oversite to unlicensed personnel and to provide direct care to residents.<br><br>LPN-C's employee record included a performance review completed on January 24, 2019. The employee record lacked required annual performance reviews due to be completed in 2020, 2021 and 2022.<br><br>ULP-H<br>ULP-H was hired by the licensee on June 19, 2021, and was observed providing direct cares to residents on August 22, 2023.<br><br>ULP-H's employee record included a performance review completed on November 19, 2019. The employee record lacked required annual performance reviews due to be completed in 2020, 2021 and 2022.<br><br>On August 21, 2023, at 10:15 a.m., during the entrance conference, regional registered nurse (RN)-E and licensed assisted living director (LALD)-D stated they were aware of the required contents of employee records.<br><br>On August 22, 2023, at 10:02 a.m., RN-E stated LPN-C and ULP-H's employee records each contained only one performance review from 2019 (listed above). RN-E stated they were behind in general on performance reviews with their employees.<br><br>No further information was provided. | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 0 650 | Continued From page 3<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=D | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to conduct TB symptom screening for one of three employees (unlicensed personnel (ULP)-H).<br><br>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 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). | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 0 660 | Continued From page 4<br><br>The findings include:<br><br>The Facility TB Risk Assessment was dated January 2023, and identified the facility was at a low risk for TB transmission.<br><br>ULP-H was hired by the licensee on June 19, 2021, and was observed providing direct cares to residents on August 22, 2023.<br><br>ULP-H's employee record lacked a baseline TB symptom screening at the time of hire.<br><br>On August 21, 2023, at 10:15 a.m., during the entrance conference, regional registered nurse (RN)-E and licensed assisted living director (LALD)-D stated they were aware of the required contents of employee records.<br><br>On August 22, 2023, at 10:02 a.m., RN-E stated they did not think they had TB symptom screenings for ULP-H and didn't think they needed symptom screening completed since they were at a low transmission rate. RN-E stated if TB screening was completed, it would be in the employee records they provided to the surveyor.<br><br>The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result.<br><br>The licensee's Tuberculosis Program for Associates policy, undated, indicated: "Baseline TB Screening for all Associates - All States Personal Risk Assessment and Symptom Screen" | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 0 660 | Continued From page 5<br><br>"3. Every new associate will begin by filling out the Personal Risk Assessment and Symptom Review. This will be reviewed by the IP to determine if further testing is required, or if the associate indicates they have a high risk condition.<br>a. For communities in IL, if they do not indicate any risk factors, they will not need to be tested further. If they answer "yes" to any of the questions on the State specific forms, they will need to follow the remaining protocol.<br>b. For communities in MN, MO and ND and WI, or those that have a positive risk assessment, a tuberculin skin test (TST) or blood test (QuantiFERON or T-spot), depending on community preference, will be performed on newly hired associates.<br>4. All reports or copies of the TST or blood work and any related chest x-ray and medical evaluation will be maintained in the associate's record.<br>5. TST documentation must include the following:<br>a. Name of the person administering the test<br>b. Date and time administered<br>c. Location administered - (L) forearm or ( R ) forearm<br>d. Tuberculin manufacturer<br>e. Tuberculin expiration date and lot number<br>f. Date and time the results are read<br>g. Number of mm of induration (measuring across the forearm) - 0 mm could be a correct response<br>h. Interpretation of the reading - either positive or negative<br>i. Readers signature<br>6. Associates with a history of BCG vaccination have the blood test done as it is much more | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 0 660 | Continued From page 6<br><br>accurate for them.<br>7. An associate may begin working with residents after a negative TB risk and symptom screen and a negative TST or blood test. If they have a record of a negative first step within 90 days before hire, a single TST should be administered in the new setting. This additional TST represents the second step in testing. However, for those receiving it for the first time, a second step will need to be done 7 - 21 days after the first step was completed.<br>8. MN- For those who have received a blood test within the last 90 days prior to hire as long as it is negative it is accepted; if outside of 90 days, must repeat the blood test or proceed with 2 step tb testing."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, | 0 800 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 0 800 | Continued From page 7<br><br>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. This deficient condition had the ability to affect a limited number of staff and residents.<br><br>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 potential to affect a large portion or all of the residents).<br><br>Findings include:<br><br>On facility tour with the Environmental Services Director (ESD)-G between approximately 9:00 AM and 11:30 AM on August 22, 2023, it was observed that the trash chute doors in each of the trash rooms (three total) did not close and positively latch as required as part of the fire rated shaft assembly. This deficient condition was visually verified by (ESD)-G accompanying on the tour.<br><br>It was also observed that carpeting in the common hallways was aging and portions had loosened or bubbled to the extent that it created a tripping hazard for anyone walking in the hallways. This deficient condition was visually verified by (ESD)-G accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 01460 SS=F | 144G.63 Subdivision 1 Orientation of staff and supervisors | 01460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01460 | Continued From page 8<br><br>All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living statutes for two of two direct care employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-H).<br><br>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).<br><br>The findings include:<br><br>LPN-C<br>LPN-C was hired by the licensee on September 8, 2015, to provide oversite to unlicensed personnel and to provide direct cares to residents.<br><br>LPN-C's employee record included a New Employee General Orientation document which included organizational onboarding and | 01460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01460 | Continued From page 9<br>orientation training dated July 16, 2015.<br><br>LPN-C's employee record included an Educare (online training platform) transcript. The Guide to Assisted Living - MN training module, which included assisted living statute training, was assigned to LPN-C on August 17, 2021, but was never completed.<br><br>ULP-H<br>ULP-H was hired by the licensee on June 19, 2021, and was observed providing direct cares to residents on August 22, 2023.<br><br>ULP-H's employee record included a New Employee General Orientation document which included organizational onboarding and orientation training dated June 29, 2021.<br><br>ULP-H's employee record included an Educare transcript. The Guide to Assisted Living - MN training module, which included assisted living statute training, was assigned to LPN-C on August 17, 2021, but was never completed.<br><br>LPN-C and ULP-H's Educare transcripts and New Employee General Orientation documents both lacked orientation to assisted living statutes.<br><br>On August 21, 2023, at 10:15 a.m., during the entrance conference, regional registered nurse (RN)-E and licensed assisted living director (LALD)-D stated they were aware of the required contents of employee records.<br><br>On August 22, 2023, at 10:02 a.m., RN-E stated they were behind on training for their employees and what they provided to the surveyor for LPN-C and ULP-H was the only orientation documentation they had. RN-E stated Educare is | 01460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01460 | Continued From page 10<br>where employees were assigned trainings to be completed.<br><br>The licensee's Additional Orientation for AL Nursing Associates policy, copyright 2021 by Benedictine, indicated, "The materials and/or type of training (i.e. video, lecture, reading, etc.) will be documented for compliance. Evidence of the completion of required orientation topics is kept in the employee record."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01460 | | |
| 01470 SS=F | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, | 01470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01470 | Continued From page 11<br><br>including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation before providing services for two of two direct care employees | 01470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01470 | Continued From page 12<br><br>(licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-H).<br><br>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).<br><br>The findings include:<br><br>LPN-C<br>LPN-C was hired by the licensee on September 8, 2015, to provide oversite to unlicensed personnel and to provide direct cares to residents.<br><br>LPN-C's employee record included a New Employee General Orientation document which included organizational onboarding and orientation training dated July 16, 2015.<br><br>LPN-C's employee record included an Educare (online training platform) transcript which included employee training.<br><br>ULP-H<br>ULP-H was hired by the licensee on June 19, 2021, and was observed providing direct cares to residents on August 22, 2023.<br><br>ULP-H's employee record included a New Employee General Orientation document which included organizational onboarding and orientation training dated June 29, 2021.<br><br>ULP-H's employee record included an Educare | 01470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01470 | Continued From page 13<br><br>(online training platform) transcript which included employee training.<br><br>LPN-C and ULP-H's Educare transcripts and New Employee General Orientation documents both lacked orientations to:<br>-current assisted living bill of rights; and<br>-principles of person-centered planning/service delivery.<br><br>On August 21, 2023, at 10:15 a.m., during the entrance conference, regional registered nurse (RN)-E and licensed assisted living director (LALD)-D stated they were aware of the required contents of employee records.<br><br>On August 22, 2023, at 10:02 a.m., RN-E stated orientation training was completed using their New Employee General Orientation and Educare and the training was consistent with all of their employees.<br><br>The licensee's Additional Orientation for AL Nursing Associates policy, copyright 2021 by Benedictine, indicated, "The materials and/or type of training (i.e. video, lecture, reading, etc.) will be documented for compliance. Evidence of the completion of required orientation topics is kept in the employee record."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01470 | | |
| 01500 SS=F | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01500 | Continued From page 14<br>for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01500 | Continued From page 15<br><br>topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment in all required training topics for two of two direct care employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-H).<br><br>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).<br><br>The findings include:<br><br>LPN-C<br>LPN-C was hired by the licensee on September 8, 2015, to provide oversite to unlicensed personnel and to provide direct cares to | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01500 | Continued From page 16<br>residents.<br><br>LPN-C's employee record included an Educare (online training platform) transcript which included employee training.<br><br>ULP-H<br>ULP-H was hired by the licensee on June 19, 2021, and was observed providing direct cares to residents on August 22, 2023.<br><br>ULP-H's employee record included an Educare (online training platform) transcript which included employee training.<br><br>LPN-C and ULP-H's records both lacked the following required annual trainings:<br>-reporting maltreatment of vulnerable adults or minors;<br>-assisted living bill of rights;<br>-infection control techniques;<br>-effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with resident's who have dementia, Alzheimer's disease or related disorders;<br>-review of provider's policies and procedures; and<br>-principles of person-centered planning/service deliver.<br><br>On August 21, 2023, at 10:15 a.m., during the entrance conference, RN-E and licensed assisted living director (LALD)-D stated they were aware of the required contents of employee records.<br><br>On August 22, 2023, at 10:02 a.m., regional registered nurse (RN)-E stated they were behind on annual training for their employees and what they provided to the surveyor for LPN-C and ULP-H was what they had. RN-E stated Educare | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01500 | Continued From page 17<br><br>is where employees were assigned annual trainings to be completed.<br><br>The licensee's MN AL Dementia Training policy, copyright 2021 by Benedictine, indicated dementia training must include:<br>"a. Understanding cognitive impairment, and behavioral and psychological symptoms of dementia,<br>b. Standards of dementia care, including nonpharmacological dementia care practices that are person centered and evidence informed.<br>c. An explanation of Alzheimer's disease and related disorders;<br>d. Assistance with activities of daily living;<br>e. Problem solving with challenging behaviors; and<br>f. Communication skills<br>g. Person-centered planning and service delivery"<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500 | | |
| 01530 SS=F | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 18<br><br>at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide employees with two hours of required annual dementia care training for two of two direct care employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-H).<br><br>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).<br><br>The findings include:<br><br>LPN-C<br>LPN-C was hired by the licensee on September 8, 2015, to provide oversite to unlicensed | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 19<br><br>personnel and to provide direct services to residents.<br><br>LPN-C's employee record included an Educare (online training platform) transcript with the most recent dementia care training having been completed on August 15, 2021.<br><br>ULP-H<br>ULP-H was hired by the licensee on June 19, 2021, and was observed providing direct cares to residents on August 22, 2023.<br><br>ULP-H's employee record included an Educare transcript with the most recent dementia care training having been completed on July 1, 2021.<br><br>LPN-C and ULP-H's records both lacked two hours of required annual dementia training with both completing zero hours of the required training.<br><br>On August 21, 2023, at 10:15 a.m., during the entrance conference, RN-E and licensed assisted living director (LALD)-D stated they were aware of the required contents of employee records.<br><br>On August 22, 2023, at 10:02 a.m., regional registered nurse (RN)-E stated they were behind on annual training for their employees and what they provided for LPN-C and ULP-H was what they had. RN-E stated the licensee used Educare to assigned annual trainings to employees.<br><br>The licensee's MN AL Dementia Training policy, copyright 2021 by Benedictine, indicated, "Staff at all of Assisted Living with Dementia must have at least two (2) hours of training on dementia every 12 months." | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 20<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a 14-day assessment no more than 14 calendar days after initiation of services | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01620 | Continued From page 21<br>for one of four residents (R1).<br><br>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 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).<br><br>The findings include:<br><br>R1 was admitted to the licensee on February 28, 2022. R1's service plan dated March 20, 2023, indicated R1 received services safety "OK" checks and medication management.<br><br>R1's record included a Resident Evaluation RN admission assessment completed on February 28, 2022. It indicated R1's next evaluation was due on March 14, 2022.<br><br>R1's record included a Resident Evaluation RN 14-day assessment completed on March 20, 2022, six days past the 14-day requirement.<br><br>On August 23, 2023, at 1:19 p.m., director of nursing (DON)-A stated R1's 14-day assessment was completed late. DON-A stated they were not employed with the licensee when R1's 14-day assessment was due but it had been their primary focus to make sure resident assessments were completed timely since they were hired.<br><br>The licensee's Initial and On-Going Assessments of Residents policy, copyright 2021 by Benedictine, indicated:<br>"1. A RN will complete the following comprehensive nursing assessments of the | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01620 | Continued From page 22<br><br>resident's physical, mental, and cognitive needs as required:<br>a. Pre-Admission Assessment<br>b. Initial assessment completed before services started<br>c. 14-day assessment: completed up to 14-days after start of services<br>d. Ongoing assessment: completed periodically but no less than every 90-days<br>e. Change in resident condition"<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01880 SS=D | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of three residents (R3) receiving medication management services.<br><br>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 | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 23<br>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).<br><br>The findings include:<br><br>R3 was admitted to the licensee on January 28, 2021, with a diagnoses of acute congestive heart failure, anxiety disorder, and osteoarthritis.<br><br>R3's Service Plan dated May 26, 2023, indicated R3 received services for stand by assist with showers, safety checks, daily weights, and medication administration.<br><br>R3's registered nurse (RN) assessment completed by director of nursing (DON)-A on July 6, 2023, indicated R3 required staff to administer medications and manage storage of medications.<br><br>On August 22, 2023, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-H set up and administer medications to R3 within the apartment. The medications were locked in an upper kitchen cabinet above the refrigerator. Next to the kitchen was a bathroom with a cabinet near the door opening with a shelf containing two liquid medication bottles. One bottle was Pepto Bismol (upset stomach) and the other was an unlabeled medication bottle containing milky green liquid. ULP-H stated they weer unaware the medications were in R3's bathroom.<br>The surveyor opened the unlocked cabinet doors above the shelf and located the following bottles of medication:<br>-Wal-Mucil capsules;<br>-Tums;<br>-flaxseed oil 1200 milligrams (mg);<br>-ibuprofen 200 mg tablets; | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 24<br><br>-calcium 600mg + D3;<br>-vitamin B12 1000 microgram (mcg) tablets;<br>-vitamin B6 100 mg tablets;<br>-medicated body powder; and<br>-Robitussin maximum strength cough and chest congestion DM.<br><br>On August 22, 2023, at 12:21 p.m., director of nursing (DON)-A stated if a resident received medication management, they would need to be assessed by an RN to see if over the counter (OTC) medications could be self-administered safely. DON-A stated families were required to notify the licensee if they planned to bring medications in.<br><br>On August 23, 2023, at 10:44 a.m., family member (FM)-J stated they brought in the Pepto Bismol recently and the other OTC medications were no longer needed since R3 had been admitted to hospice care. FM-J stated they were okay with the medications being removed.<br><br>On August 23, 2023, at 12:57 p.m., ULP-I stated if they came across medications in a resident's room who received medication management, they would check the electronic medication administration record (eMAR) to see if those medications were listed. ULP-I stated, "I would notify the nurse, it could save someone's life."<br><br>On August 23, 2023, at 1:02 p.m., DON-A stated R3's RN assessment did not have any specific storage information for R3 except that medications would be stored in a locked cabinet and any narcotic medications in a medication cart. DON-A stated they were unaware there were OTC medications in R3's bathroom. They stated staff had been trained to notify a nurse if medications were found unlocked in a resident's | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 25<br><br>room. DON-A also stated families often brought in medications without licensee knowing, and she has told families to let her know before bringing in any medications.<br><br>The licensee's 2.07 Medication & Treatment Orders-Receiving, Implementing, Renewal and Re-ordering policy dated August 1, 2021, indicated when a pharmacy delivery arrives, medication will be checked in and place in appropriate storage areas according to the individualized service plan.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for one of four residents (R2).<br><br>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 an | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 26<br><br>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).<br><br>The findings include:<br><br>R2's Service Plan With Schedule signed May 24, 2023, indicated R2 received medication administration and diabetic management.<br><br>R2's record included orders signed on July 12, 2023, which indicated R2 received:<br>-blood glucose checks before meals at 7:15 a.m., 11:15 a.m., and 4:15 p.m.;<br>-Lantus Solostar insulin pen U-100, 100 units (u)/milliliter (ml) (3ml), 34u subcutaneously at bedtime; and<br>-Novolog FlexPen insulin U-100, 100 u/ml (3ml), give 5u subcutaneously before each meal.<br><br>R2's record included an electronic medication administration record (EMAR) which indicated R2 received the following medications:<br>-Lantus Solostar insulin; August 20-22, 2023, at 8 p.m., which was 29, 30, and 31 days after the opened-on date; and<br>-Novolog FlexPen insulin; August 23, 2023, at 7:30 a.m., which was 29 days after the opened-on date.<br><br>On August 22, 2023, at 7:59 a.m., the surveyor observed R2's medication cupboard with unlicensed personnel (ULP)-B. The surveyor showed ULP-B the opened-on date for the Lantus Solostar insulin pen, July 22, 2023, and the Novolog FlexPen insulin, July 25, 2023. ULP-B stated they did not know the insulin pens expired 28 days after being opened. ULP-B realized and stated the Lantus Solostar insulin pen was | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 27<br><br>expired. Surveyor stated the Novolog FlexPen insulin would also be expired on August 23, 2023, (the next day). ULP-B stated the nurses were supposed to go through resident medications and make sure nothing had expired. ULP-B stated if they found a medication past its opened-on date they would tell the nurse but is hard to do when they didn't know when the insulin pens expired.<br><br>On August 22, 2023, at 12:08 p.m., director of nursing (DON)-A stated the floor nurses were responsible for checking medication cupboards and were supposed to do it on a weekly basis. DON-A stated the insulin pens were only good for 30 days after their opened-on date and ULP's were supposed to let nurses know if a medication was expired.<br><br>On August 23, 2023, at 10:30 a.m., the surveyor observed R2's medication cupboard with ULP-B. The expired Lantus Solostar insulin pen had been removed and replaced with a new one. The Novolog FlexPen insulin, opened-on date July 25, 2023, remained in the cupboard and expired as of August 23, 2023 (date of observation). ULP-B stated they administered R2's Novolog FlexPen insulin at 7:30 a.m., today (August 23, 2023) with the expired Novolog FlexPen insulin and had notified nursing it would be expired on August 23, 2023.<br><br>On August 23, 2023, at 1:19 p.m., DON-A stated on August 22, 2023, they were notified by ULP-B of the expired, and soon to be expired, insulin pens for R2's and had instructed one of their nurses to follow-up on removing them from the medication cupboard. DON-A stated the nurse should have removed the Novolog FlexPen insulin when they audited R2's medication cupboard. | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 28<br><br>The licensee's provided medication policies did not address medication opened-on dates, medication expiration dates or medication expiration audits to be completed by a nurse.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02310 SS=I | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R3, R6) who utilized consumer bed rails (grab bars). Additionally, the licensee failed to document measurements of entrapment zones for R2 who utilized a hospital bed rail.<br><br>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 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 | 02310 | On August 23, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 29<br>situation has occurred only occasionally).<br><br>An immediate correction order was issued on August 22, 2023, at 5:32 p.m.<br><br>The findings include:<br><br>CONSUMER BED RAIL/GRAB BAR<br>R3 was admitted to the licensee on January 28, 2021, with diagnoses of acute congestive heart failure, anxiety disorder, and osteoarthritis.<br><br>R3's Service Plan dated May 26, 2023, indicated R3 received services for stand by assist with showers, safety checks, daily weights, and medication administration.<br><br>R3's change of condition assessment completed by director of nursing (DON)-A on July 6, 2023, indicated under the category of assistive device, "as needed" for frequency of the use of side rail or grab bar or other device during bed use. No additional information related to the grab bar was provided on the assessment.<br><br>On August 22, 2023, at 9:10 a.m., the surveyor observed R3's hospital bed with Halo (circular) grab bars on each side of the head of the bed. R3 was lying in bed sleeping. The Halo bars were fixed tightly to the bed.<br><br>R3's medical record lacked a bed rail assessment to include the following:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment;<br>- Risk vs. benefits discussion (individualized to each resident's risks); | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 30<br><br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.<br>Additionally, R3's record lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information.<br><br>On August 21, 2023, the licensee provided the surveyor with a Current Resident Roster dated August 21, 2023. R3 was not identified on the roster to have a bed rail.<br><br>R6<br>R6 was admitted to licensee on July 7, 2020, with diagnoses of generalized anxiety disorder, chronic heart failure, and type II diabetes.<br><br>R6's Service Plan dated April 11, 2023, indicated R6 received services for bathing, medication administration, blood glucose monitoring, and laundry.<br><br>R6's Side Rail Assessment dated June 21, 2023, indicated R6 had a grab bar which was not secured to a standard bed and was "not in use." The assessment indicated the RN did not check for recall on R6's grab bar and recommended the removal of grab bar as it was not in use. The assessment did not indicate alternative options offered. The assessment indicated a pillowcase was used over the bed rail, although this was not observed by the surveyor. The side rail | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 31<br><br>assessment lacked the following:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment;<br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.<br>Additionally, R6's record lacked evidence the licensee referred to the CSPC for the most up-to-date information related to portable bed side rail recall information.<br><br>During observation and interview on August 22, 2023, at 1:40 p.m., the surveyor observed a rectangular grab bar on the right side of a queen bed with two horizontal bars which slid in between the mattress and box spring. The grab bar had two straps on each end that were not attached to the bed frame. The grab bar was able to be pulled out easily. R6 indicated she slept on the left side of the bed and used her four-wheel walker to hold onto while getting in and out of bed. The surveyor asked R6 if she wanted the grab bar on the left side of the bed, and she said yes. R6 stated she used to have it on the left side, but had it switched to the right side when she had right shoulder issues. Surveyor asked if the licensee ever offered to have it moved back to the left side and R6 said no. R6 then stated she was open to other grab bar alternatives but had not | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 32<br>been offered them.<br><br>HOSPITAL BED RAIL/SIDE RAIL<br>R2 was admitted to licensee on November 9, 2021, with diagnoses of altered mental status, type II diabetes, and personal history of traumatic brain injury.<br><br>R2's Service Plan dated May 24, 2023, indicated R2 received services for stand by assist with showers, safety checks, laundry, blood glucose monitoring, and medication administration.<br><br>R2's Side Rail Assessment dated May 24, 2023, indicated R2 had a side rail on right side of bed. The assessment indicated Zones one through four met federal recommendations but did not include actual measurements. The side rail assessment lacked the following:<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; and<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation per manufacturer guidelines.<br><br>On August 21, 2023, at 12:40 p.m., during an interview with R2, the surveyor observed a hospital bed with side rail on right side of bed. R2 stated she used the side rail to help maintain her independence. The side rail was installed firmly.<br><br>On August 22, 2023, at 11:30 a.m., regional director of housing (RN)-E stated the licensee had a new side rail policy and side rail assessment form which would be implemented, and staff trained once final approval occurred.<br><br>On August 22, 2023, at 11:55 a.m., DON-A stated their practice for checking side rails and | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 33<br><br>consumer grab bars included assessing the resident to make sure it was safe to use, going over the risk versus benefits with the resident and/or their designated representative, measurement of the entrapment zones if it is a FDA hospital bed rail and check to see if the consumer grab bar is installed per manufacturer guidelines. She stated the assessments occur every 90 days. Regarding R3, DON-A stated she knew the hospital bed was delivered after R3 was admitted to hospice, but she did not know when the Halo grab bars arrived. She stated staff did not inform her when they arrived and stated she should have followed up to check. DON-A stated the floor nurses are responsible for notifying DON-A when a new assistive device appears on a resident's bed. When asked who was responsible for checking for recalls, DON-A stated she did not know and said, "I guess it would fall on me, I would have to check the policy."<br><br>On August 22, 2023, at 3:48 p.m., DON-A stated no facility wide audits had been completed, or had been requested to be completed by corporate nursing for bed rails since they became the interim DON. DON-A stated when hired they did not receive formal training for bed rail assessments and when hired they tried to pick up where the last DON left off. DON-A stated they were told assessments were severely behind and that became their main focus. DON-A stated ULPs were not trained to update nursing on any new equipment including side rails or grab bars but it would be a good idea for them to be trained to do so. DON-A stated they had completed most of the assessments for residents themself in order to become familiar with the residents and to be able to review resident's assessment history. DON-A stated they typically complete | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 34<br><br>assessments in the resident's room if they can and did so on paper. DON-A stated the paper assessment they used did not include all topics so it could be difficult to remember what all needed to be assessed, they would like to be able to have a laptop to bring with them to improve assessments and make them easier to complete. DON-A stated they try to remember who had bed rails when doing assessments but was difficult to do. DON-A stated they did not check to see if R6's consumer grab bar was recalled since R6 wasn't using it despite the grab bar being left on the bed. DON-A stated the risk versus benefits was completed without checking for a product recall or consulting manufacturer instructions for proper installation. DON-A stated they did not feel well supported by the organization.<br><br>On August 22, 2023, at 4:02 p.m., RN-E stated as an organization, they perform "mock trials" to perform audits ensuring compliance of 144G regulations. RN-E stated DON-A received onboarding training when she started working for licensee. RN-E also indicated all ULPs are trained to notify nursing when an assistive device appears in a resident's room. RN-E stated every community is provided a computer/lap top to perform in person assessments with each resident, if one was not available, detailed notes would be expected.<br><br>The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated 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 | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 35<br><br>bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep 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."<br><br>The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment; | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21947 | A. BUILDING: _____ B. WING _____ | 08/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CERENITY RESIDENCE - MARIAN OF | 225 FRANK STREET SAINT PAUL, MN 55106 |

| (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 36<br><br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".<br>Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.<br><br>The licensee's Side Rails Policy dated June 3, 2022, indicated the RN would document bed rail assessments using the matrix senior elite bedrail form, which included documentation of the measurement ranges required to meet the FDA guidelines. If the RN determines that the side rails were not safe device for the resident, the RN would provide options and alternatives for reducing falls or maximizing independence to the resident, the resident's representative and/or the resident's family. Additionally, the policy indicated the RN would document these recommended options and the response from the response from the resident, resident's family and resident's representative to the RN's recommendations.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 02310 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *08/22/23*
Time: 15:38:41
Report: 1018231139

# Food and Beverage Establishment Inspection Report



**Location:**
Cerenity Residence - Marian Of
225 Frank Street
St Paul, MN55106
Ramsey County, 62

**Establishment Info:**
ID #: 0039236
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6514951830
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.

No NEW orders were issued during this inspection.

**Surface and Equipment Sanitizers**

SMARTPOWER: = 700PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

---

Hot Water: = at 162 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

---

Hot Water: = at 162 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding/ MILK
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

---

Process/Item: Cold Holding/ YOGURT
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

---

Process/Item: Cold Holding/ CHICKEN
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

---

Process/Item: Cold Holding/ CHEESE
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Type: Full
Date: *08/22/23*
Time: 15:38:41
Report: 1018231139
Cerenity Residence - Marian Of

# Food and Beverage Establishment Inspection Report

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

ESTABLISHMENT USES ALL PASTEURIZED EGGS AND COOKS ONLY GROUND BEEF FROM RAW. ALL OTHER MEAT ITEMS ARE FULLY COOKED.

ESTABLISHMENT DOES ALL SAME DAY SERVICE FOR FOODS AND NO COOLING TAKES PLACE.

DISCUSSED TEMPERATURE LOGS, EMPLOYEE ILLNESS AND PEST CONTROL.

NO ORDERS ISSUED.

**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 1018231139 of 08/22/23.

Certified Food Protection Manager: CRYSTAL L ROSENBLOOM

Certification Number: FM90993 Expires: 04/29/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
CRYSTAL ROSENBLOOM
KITCHEN MANAGER

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us