Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 24, 2025

Administrator
Cerenity Marian Of St Paul LLC
200 Earl Street
Saint Paul, MN 55106

RE: CCN: 245365
Cycle Start Date: February 6, 2025

Dear Administrator:

On February 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 11, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 11, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 11, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs

offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 11, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cerenity Marian Of St Paul Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 11, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 6, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A

written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY MARIAN OF ST PAUL LLC	200 EARL 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) COMPLETION DATE
E 000	Initial Comments On 2/3/25 - 2/6/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/3/25-2/6/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53656922 (MN00110453) and H53656862C (MN00110486) with a deficiency cited at F760. The following complaints were reviewed with no deficiencies cited: H53656583C (MN00106665) H53656582C (MN00104108). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/04/2025

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure medications were administered per physicians' orders for 2 of 2 (R6, R150) residents reviewed for medication errors. This resulted in significant medication errors and actual harm when R6 received the wrong medications resulting emergent care and hospitalization for hypotension (low blood pressure), lethargy, and possible aspiration. Findings include: R6's quarterly Minimum Data Set (MDS) dated 12/26/24, indicate R6 had severe cognitive impairment and diagnoses of dementia, depression and high blood pressure. Furthermore, R6's MDS indicated R6 did not take narcotic medications. R6's Safety Events- Medication Error report dated 2/2/25, indicated R6 received R229's medications. The medications R6 received in error included the following: -Methadone (narcotic pain medication) 2.5 milligrams (mg) -gabapentin (medication to treat nerve pain)	F 760	Resident #6□s picture in the EMR (Electronic Medical Record) was retaken to ensure clarity. Resident #6 has been receiving the correct medications. Resident #6 returned to the facility and is at baseline. Resident #150 has an armband on with her name for proper identification. Resident #150 has been receiving the correct medications. Resident #150 returned to the facility and is at baseline; no services were provided to resident #150 at the ER. All residents receive the proper medication. Facility will continue to follow their procedure for if/when there is a medication event. All licensed staff and TMAs (trained medication aides) have been re-trained on the 6 rights of medication administration. All resident pictures in the EMR have been audited to ensure that they are clear; retakes completed. The staff person responsible for taking pictures was re-educated on 2/4/2025 on expectations	3/4/25

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F 760	Continued From page 2 900mg -omeprazole (medication to prevent acid reflux) 20mg -senna (medication to prevent constipation) 2 tablets -tamsulosin (medication to treat enlarged prostrate) 0.4mg -MiraLAX 17grams (medication to prevent constipation) The report further indicated R6's blood pressure had decreased from >100 systolic to 55 systolic over the course of 2 hours. Staff gave Narcan (medication to reverse the effects of narcotic medication) and R6 transferred to a higher level of care. Furthermore, R6 required additional observation overnight in the hospital. R6's provider orders lacked indication R6 had been prescribed Methadone, gabapentin, omeprazole, senna, tamsulosin or MiraLAX. R6's nursing progress note dated 2/2/25 at 9:28 a.m., indicated R6 had been given R229's morning medications. The error was noted at 9:00 a.m., and R6's vital signs were blood pressure (BP) 105/57, pulse 65, 97% oxygen saturation on room air. The on-call provider was notified and instructed vital signs to be taken every hour for 12 hours, then every 4 hours for 24 hours. If R6 became sedated, staff should administer Narcan and send to the hospital. R6's nursing progress note dated 2/2/25, at 1:39 p.m., indicated the provider was notified R6's blood pressure was low. R6's nursing progress note dated 2/2/25 at 2:39 p.m., indicated R6 had been transferred to the	F 760	for clear and unobstructed pictures for the EMR. Any resident who declines a picture has an armband on for resident identification. Med pass audits, conducted by licensed staff, to ensure that the 6 rights of medication administration are being followed have been implemented. Audit schedule: first 4 weeks will be 3 audits/floor/week, next 4 weeks will be 2 audits/floor/week, and the following 4 weeks will be 1 audit/floor/week to ensure compliance. Issues identified with medication administration will be forwarded to the facility□s QAPI Team for input/suggestions. The Director of Nursing is responsible for ensuring that medications are given per NP/MD orders.	

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F 760	Continued From page 3 hospital. R6's vital signs dated 2/2/25 indicated the following: -at 11:06 a.m., BP was 107/67 and pulse 61 -at 12:34 p.m., BP was 98/62 and pulse 52 -at 1:35 p.m., BP was 55/35 and pulse 56 R6's Hospital Medicine History and Physical dated 2/2/25, at 8:14 p.m., indicated R6 was admitted for accidental ingestion and refractory hypotension. In the emergency department, R6 had ongoing sedation and hypotension. R6's mental status improved to near baseline however the hypotension continued. R6 had normal respirations and did not require supplemental oxygen. There was some concern for aspiration and R6 was started on an antibiotic however there was low suspicion for an infection onset prior to the accidental ingestion as it was reported R6 was in usual state of health before medication administration. R6 was admitted for close monitoring and management of blood pressures. R229's admission MDS dated 1/26/25, indicated R229 was cognately intact and had a diagnosis of bone cancer. R229 received hospice services. When interviewed on 2/4/25 at 9:04 a.m., family member (FM)-A stated R6 was given the wrong medication on 2/2/25. FM-A stated there was a newer nurse and R6 was given R229's morning medications as both had the same first name. FM-A stated they had been in contact with the hospital and due to the Methadone and gabapentin, R6's blood pressure was low and needed intravenous fluids and monitoring. When interviewed on 2/5/25 at 10:27 a.m.,	F 760		

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F 760	Continued From page 4 trained medication assistant (TMA)-A stated they were working with licensed practical nurse (LPN)-A on 2/2/25 when the medication error happened. TMA-A stated during medication pass, LPN-A asked if there were any of his residents in the dining room. TMA-A stated R6 was seated in the dining room for breakfast and told LPN-A. R6 from room 4012 was. TMA-A stated LPN-A went over to where R6 was seated and administered medication. A short while later, LPN-A then asked where R6 was. TMA-A stated R6's medications were given as R6 was seated in the dining room. TMA-A asked LPN-A if R229's medications were given to R6 as they have the same first name. It was then LPN-A had realized he administered R229's medications to R6. TMA-A stated LPN-A had notified the provider and monitored R6 for any changes. TMA-A stated R6 appeared to have a "normal morning" and had normal behaviors during breakfast. At one point, TMA-A stated R6 wanted to lay down and did before lunch. TMA-A stated when R6 came out for lunch, R6 was falling asleep during lunch at the dining room table. TMA-A stated this was unusual for R6. R6 appeared weak and very tired so he was laid back in bed. That was when R6's blood pressure was 50's over 30's. LPN-A had notified the provider again and gave Narcan. R6 was then sent into the emergency room. TMA-A stated R6 appeared to have a normal morning before the wrong medications were given and after, appeared to be tired and lethargic. When interviewed on 2/5/25 at 10:42 a.m., registered nurse (RN)-A stated nurses should be making rounds and introducing themselves when they were new to the unit. RN-A further stated residents could be identified with their pictures,	F 760		

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F 760	Continued From page 5 names on their rooms and by other staff who worked the units regularly. RN-A acknowledged LPN-A gave R229's medications to R6 in error and further stated there were two residents with the same name. LPN-A had worked on other units in the building however it was the first time working on this floor. RN-A expected nursing staff to use the seven rights for medication administration and verify the correct resident received the right medications. When interviewed on 2/5/25 at 1:30 p.m., nurse practitioner (NP)-A was aware R6 had been given R229's medications in error. NP-A further stated the medication error "absolutely contributed "to R6's low blood pressure and was the reason R6 required additional monitoring in the hospital. When interviewed on 2/5/25 at 2:35 p.m., clinical pharmacist (CP) was aware of R6's medication error. CP stated R6 had received R229's methadone and gabapentin which had the greatest potential for a negative outcome. CP explained the methadone dose was low; however, gabapentin can potentiate the methadone making it have greater effects. CP stated this was a significant medication error that resulted in R6 needing hospitalization. When interviewed on 2/6/25 at 8:49 a.m., the administrator acknowledged R6's medication error and need for hospitalization. The administrator further stated the unit had two residents with the same first name and LPN-A did not clarify the correct name when giving morning medications. The administrator had been leading the facility investigation into the error. The administrator stated education was ongoing for all nurses and TMAs before the start of their shift	F 760		

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F 760	Continued From page 6 about resident identification. Furthermore, pictures of all residents have been reviewed to ensure they were up to date and clear. When interviewed on 2/6/25 at 11:49 a.m., the Director of Nursing (DON) expected all staff to utilize the 7 rights of medication administration. DON further stated there were names on the doors, pictures on file, or staff who were nor familiar with the unit were expected to verify with other staff who normally worked on the unit. R150's initial Minimum Data Set (MDS) dated 1/30/25, indicate R150 had severe cognitive impairment. R150's face sheet indicated R150 had diagnoses of humerus fracture, type 2 diabetes mellitus, chronic kidney disease, and hearing loss. R150's Safety Events- Medication Error report dated 2/3/25, indicated R150 received R149's medications. The medications R150 received in error included the following: -amlodipine (medication totreat high blood pressure) -citalopram (medication to treat depression) -furosemide (medication to treat fluid retention) -gabapentin (medication to treat seizures and peripheral neuropathy) -metformin (medication to treat type 2 diabetes) R150's provider orders lacked indication R150 had been prescribed amlodipine, citalopram, furosemide, gabapentin, or metformin. R150's nursing progress note dated 2/3/25 at 10:10 a.m., indicated R150 had received wrong medication given by nurse from other unit. R150's vital signs were blood pressure (BP) 109/65,	F 760		

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F 760	Continued From page 7 heart rate 92bpm (beats per minute), respirations 17, O2sat (oxygen saturation) 97% and temperature 97.5 F. The on-call provider was notified and instructed to hold the PRN Oxycodone (as needed pain medication) for 24 hours, and to check vital signs every hour and monitored for any adverse reaction accordingly. R150's nursing progress note dated 2/3/25, at 1:13 p.m., indicated "the resident was observed slashing around in bed with her bed at the end of the bed and feet at the pillow(sic). Resident was yelling out and son is present. He was unable to get her to tell him what was wrong and bothering her. Son sat with resident and writer called NP Nurse practioner) to give update. NP gave order to send resident to the ED (emergency department) for cardiac monitoring due to resident receiving another residents medication this morning." R150's nursing progress note dated 2/3/25 at 5:40 p.m., indicated R150 returned to facility by hospital transport at this time. R150's Hospital After visit summary dated 2/3/25, at 6:16 p.m., indicated R150 was at the emergency room from 1428 (2:28 p.m.) until discharge at 1700 (5:00 p.m.). In the emergency department, the hospital "looked at the doses of medications you accidentally took, and spoke to poison control. No additional monitoring needs to be performed." When interviewed via telephone on 2/5/25 at 11:36 a.m., Licensed Practical Nurse (LPN)-A stated she was working on 2/3/25 on the 3000	F 760		

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	245365	A. BUILDING _____ B. WING _____	C 02/06/2025

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F 760	Continued From page 8 floor. They indicated it was their first shift at the facility. They came in early for training, and started doing medication administration by going room to room. They indicated R150 and R149's room were next to each other. They indicated they dished up 149's medication, and were distracted, and went into R150's room and administered R149's medications. They went to the medication cart and immediately realized they had given the wrong resident the wrong medication and immediately reported it to the Registered Nurse (RN) on the floor When interviewed on 2/5/25 at 9:20 p.m.,NP-A was aware R150 had been given R149's medications in error. NP-A further stated she was here when the medication error occurred, as was R149's doctor. NP-A indicated they discussed the medications R150 had received and were concerned that the gabapentin might interact with the other medications. NP-A indicated they were notified later in the afternoon that the resident was restless and to send them to the emergency room . When interviewed on 2/5/25 at 2:35 p.m., clinical pharmacist (CP) was aware of R150's medication error. CP stated R150 had received R149 's metformin and might cause R150 stomach issues. CP indicated the medication was nothing really dangerous, and the emergency department sent her back without further orders When interviewed on 2/6/25 at 8:57 a.m., the administrator acknowledged R150's medication error and need for emergency room visit. The administrator further stated she had not yet spoke to LPN-B, but would get her statement. The administrator had been leading the facility	F 760		

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F 760	Continued From page 9 investigation into the error as it was the second one in two days. The administrator stated education was ongoing for all nurses and TMAs before the start of their shift about resident identification, and following the seven rights of medication administration. When interviewed on 2/6/25 at 11:49 a.m., the Director of Nursing (DON) expected all staff to utilize the 7 rights of medication administration. DON further stated there were names on the doors, pictures on file, or staff who were nor familiar with the unit were expected to verify with other staff who normally worked on the unit. A facility policy titled Medication Administration revised 8/31/23, directed staff to administer medications by ensuring the right resident, right medication, right dose, right time, right route, and right documentation.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		3/4/25

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F 812	Continued From page 10 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure dishwasher temperatures were within range to ensure resident dishes were sanitized for 3 of 3 kitchenettes located on resident units. Furthermore, the facility failed to ensure expired milk was removed from 1 of 3 kitchenettes (3rd floor) and clean resident dishes were stored to prevent contamination from dust/debris for 1 of 3 kitchenettes located on resident units (4th floor). This had the potential to impact all residents who reside in the facility. Findings include: A facility document titled 3rd and 4th floor Dish Machine from Ecolab dated 2024, indicated the operating temperatures were a minimum wash temperature of 155 degrees Fahrenheit (F) and a minimum rinse temperature of 180 degrees F. A facility document titled 5th floor Dish Machine from Ecolab dated 2018, indicated the operating temperatures were a minimum wash temperature of 150 degrees F and a minimum rinse temperature of 180 degrees F. 4th floor Kitchenette A facility document titled Dish Machine Temperature Log 4th floor dated 2/2025, indicated 5 of 5 days had final rinse temperatures	F 812	The facility's dish machines are both high-temp rinse and use chemicals for sanitation. The test strips for PH levels are tested twice daily and documented; rinse temps are also documented twice daily. The dusty vents in the kitchen areas were immediately cleaned by maintenance. The expired milk, and the undated milk, were thrown away. Dish machine manufacturer's information was obtained for all 4 dish machines from Ecolab. Culinary staff were educated on the use of the T-sticks (for PH levels) as well verifying rinse temps meet, or exceed 180 degrees. Rinse temps are documented twice daily on each floor as well as documentation of the T-stick testing for chemical balance. The Culinary Director, or her designee, will be auditing for expired milk/food products, dust on vents, and proper dish machine functioning. Audit schedule: first 4 weeks will be 3 audits/floor/week, next 4 weeks will be 2 audits/floor/week, and the following 4 weeks will be 1 audit/floor/week to ensure compliance. Issues identified through the audits will be forwarded to the facility's QAPI Team for input/suggestions.	

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F 812	Continued From page 11 at 180 degrees F or above, however, 0 of 5 days had wash temperatures documented at 155 degrees F or above. A facility document titled Dish Machine Temperature Log dated 1/2025, indicated 17 of the 31 days had final rinse temperatures of 180 degrees F or above. The log further indicated 0 of the 31 days, had wash temperatures were documented at 155 degrees F or above. On 2/3/25 at 2:01 p.m., the 4th floor kitchenette was reviewed. An Ecolab dishwasher was used to cleaning resident plates from lunch. Dishwasher temperatures were observed to be 109 degrees for a wash cycle and 185 degrees for the rinse cycle. Culinary aide (CA)-A unloaded clean plates from the dishwasher and stacked them onto a plate storage container. The plates were not covered. Above the clean plates was an air grate that was visibly dirty with gray dust and dirt. There were strands of dust hanging down from the grate. When interviewed on 2/3/25 at 2:10 p.m., CA-A stated the dishwasher used chemicals to sanitize resident dishes. CA-A further stated dishwasher temperatures were monitored at mealtimes and documented on a temperature log, but litmus strips to ensure the appropriate chemical sanitizing was not completed on the resident units. CA-A verified the dust/debris in the grate above the clean dishes and was not sure how often or who was responsible to clean them. When interviewed on 2/3/25 at 2:16 p.m., maintenance (M)-A verified the dust and debris in the grate. M-A was not sure who cleaned those vents and would check with their supervisor.	F 812	The Culinary Director is responsible for ensuring that milk/food items are not expired, that vents are cleaned, and that the dishes are being properly sanitized on each floor.	

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F 812	Continued From page 12 5th floor Kitchenette A facility document titled Dish Machine Temperature Log 5th floor dated 2/2025, indicated the 1 of 5 days had final rinse temperatures of 180 degrees F or above. The log further indicated 2 of the 5 days had wash temperatures documented at 150 degrees F or above. A facility document titled Dish Machine Temperature Log 5th floor dated 1/2025, indicated 13 of the 31 days had final rinse temperatures of 180 degrees F or above. The log further indicated 6 of the 31 days, had wash temperatures were documented at 150 degrees F or above. On 2/4/25 at 8:14 a.m., the 5th floor kitchenette was reviewed. An ecolab dishwasher was in use washing resident dishes. The wash temperature was 159 degrees, and the rinse temperature was 182 degrees. When interviewed on 2/4/25 at 8:18 a.m., CA-B stated the dishwasher was a high temperature dishwasher and temperatures were monitored and documented on the temperature log. CA-B stated twice a day temperatures were monitored usually at lunch and dinner. CA-B verified the last temperatures documented were 124 degrees for washing and 165 for rinse on 2/3/25 at 6:16 p.m. 3rd floor kitchenette A facility document titled Dish Machine Temperature Log 3rd floor dated 2/2025, indicated the 0 of 5 days had final rinse	F 812		

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F 812	Continued From page 13 temperatures of 180 degrees F or above. The log further indicated 0 of the 5 days had wash temperatures documented at 150 degrees F or above. A facility document titled Dish Machine Temperature Log 3rd floor dated 1/2025, indicated 6 of the 31 days had final rinse temperatures of 180 degrees F or above. The log further indicated 6 of the 31 days, had wash temperatures were documented at 150 degrees F or above. On 2/4/25 at 8:23 a.m., the 3rd floor kitchenette was observed. In the refrigerator were 5 individual containers of prairie farms 1% chocolate milk with best by dates of 2/2/25. Next to the chocolate milk were stacks of individual Glenview Farms skim milk. Two of the skim milk containers had no best by dates on them. The rest of the skim milk containers had a best by date of 2/12/25. An Ecolab dishwasher was started, and a wash temp was 155 degrees and a rinse temp was 165 degrees. When interviewed on 2/4/25 at 8:52 a.m., CA-C verified the chocolate milk's best by date was 2 days ago and stated they should not be in here. CA-C removed them and threw them away. CA-C further stated sometimes the milk does not have a best by date stamped on but all of the milks come out of the same box. If a milk didn't have a date and the other milks around it had a date, it was ok to go by that one as they would all be the same. CA-C verified the dishwasher rinse temperature did not reach 180 degrees and further stated it usually did. CA-C stated if the temperatures were not high enough, the dishes would be washed a second time. CA-C then	F 812		

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F 812	Continued From page 14 started the dishwasher again. When interviewed on 2/6/25 at 11:15 p.m., the culinary director (CD) stated the dishwashers on the resident floors used chemicals to sanitize dishes. CD verified litmus strips were not used on the floor to ensure the effectiveness of chemicals and only the temperatures were monitored. CD wasn't sure what the temperatures should be and would follow up. CD stated the CA's stocked the unit kitchenettes daily and expected any outdated items to be removed and expected staff to have removed the chocolate milk. CD was not aware of missing best by dates on the individual cartons of milk however expected a process to ensure the dates were known. CD stated there had been issues with dirty vents on the 4th floor and stated when dirty vents were noticed, maintenance should be notified so they can be cleaned. When interviewed on 2/6/25 at 12:48 p.m., the Administrator stated the CD would know what kind of dishwashers were used on the resident units and expected the guidelines to be followed to ensure resident dishes were clean and sanitized. Furthermore, the Administrator expected any dust or dirty vents/grates to be cleaned and items removed from stock that were outdated. A follow up interview on 2/6/25 at 2:32 p.m., the CD verified the dishwashers on the units were all high temperature sanitizing and did not use chemicals to sanitize. CD verified the temperature logs did not always indicate the dishwashers were getting to the correct temperatures and expected staff to notify her so follow up with Ecolab could be completed.	F 812		

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F 812	Continued From page 15 A facility policy titled Dishwashing Procedures no date, directed staff to operate in accordance to the manufactures instructions and the final sanitizing rinse will be 180 degrees F. A facility policy titled Food Storage- Perishable revised 2019, did not direct staff on a process for review of best by dates on items stored in the refrigerators.	F 812		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on February 4, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cerenity-Marian of St. Paul, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/05/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Cerenity Care Center Marian is a 5-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type I(332) construction. In 1969 a 2 story addition was constructed above the 3rd story that was determined to be of type I(332) construction. In 2002 a 1 story addition was constructed to the north that was determined to be Type I(332) construction. In 2019, floors 2, 3,	K 000		

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K 000	Continued From page 2 4 and 5 underwent renovations maintaining Type I (332) construction. The facility has a capacity of 90 beds and had a census of 80 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		3/10/25

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K 321	Continued From page 3 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. This deficient finding could have a widespread impact on the patients within the facility. Findings include: On 02/04/2025 between 08:30 AM and 11:30 AM, it was revealed by observation and staff interview, that 2 Oxygen Concentrators were being stored within a room marked as Oxygen Storage and the door to the room was not properly rated. On 02/04/2025 between 08:30 AM and 11:30 AM, it was revealed by observation and staff interview, that the Data Room was identified as a Hazardous Room with penetration on the corridor wall side of this room. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 321	The O2 room door is properly rated; however, the tag was inadvertently removed during construction. The penetration to the corridor wall from the data room was re-caulked. The facility is in the process of purchasing a new door to the O2 room. A company has been contacted is coming out to measure dimensions on 3/6/2025. All penetrations are properly caulked with fire caulk. The Director of Environmental services is responsible for ensuring doors have the proper fire rated tags on them and that penetrations are caulked. Any noted variance will be addressed/fixed.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		3/10/25

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CERENITY MARIAN OF ST PAUL LLC	**200 EARL 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) COMPLETION DATE
K 345	Continued From page 4 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.2, and 14.6.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/04/2025 between 8:30 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of the following: 1. The annual fire alarm testing report showed that 4 smokes, 4 heat detectors, 1 water flow and 3 sprinkler supervisory switches hadn't been tested in the report dated 9/25/24. 2. Smoke detector sensitivity report was not available at the time of this survey. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 345	The company that does our fire alarm testing is coming back out on 3/7/2025 to test the 4 smoke heads, 4 heat detectors, 1 water flow and 3 sprinkler supervisory switches. The smoke detector sensitivity report is completed. The annual fire alarm testing report will be carefully reviewed for completion in subsequent years to ensure that no areas were missed. The Director of Environmental Services is responsible for ensuring that the fire alarm testing company completes all required tasks.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		3/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/04/2025**

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K 355	Continued From page 5 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2, 7.2.1.2, 7.2.4. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 02/04/2025, between 8:30 AM and 11:30 AM, it was revealed by observation, that there a fire extinguisher in the 4th floor Data Room free standing not secured. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 355	The freestanding fire extinguisher in the 4th floor data room was removed. There are no more freestanding fire extinguishers in the building. The Director of Environmental Services is responsible for ensuring that all fire extinguishers are properly stored and checked monthly.	
K 930 SS=F	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 930		3/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/04/2025**

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K 930	Continued From page 6 Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/04/2025 at 8:30 AM and 11:30 AM, it was revealed by observation that in resident rooms 5023, there were two liquid oxygen containers being stored within this room and in room 4026, there were 5 liquid oxygen containers being stored within this room. These are patient rooms that are not rated for this type of storage. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 930	The stored concentrators were removed from the resident rooms. All resident rooms were checked for stored cylinders/concentrators; items were removed. The Environmental Services Director, or his designee, will audit resident rooms X2/week for 12 weeks to ensure compliance. The Executive Director or Director of Nursing will be a liaison between the facility and the oxygen company for timely pick-ups of empty tanks. The Environment Services Director is responsible for ensuring that O2 is not stored in resident rooms.	