DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KPJR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00354

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245365**

2.STATE VENDOR OR MEDICAID NO.
(L2) **723816900**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY - MARIAN OF ST PAUL LLC**
(L4) **200 EARL STREET**
(L5) **SAINT PAUL, MN** (L6) **55106**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/15/2017**

6. DATE OF SURVEY **12/16/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)
13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 12/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/30/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
06201 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
12/14/2021 (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2021

CMS Certification Number (CCN): 245365

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 1, 2021 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2021

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

RE: CCN: 245365
Cycle Start Date: October 21, 2021

Dear Administrator:

On November 16, 2021, we notified you a remedy was imposed. On December 16, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 1, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 21, 2022, did not go into effect. (42 CFR 488.417 (b))

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KPJR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00354

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(L1) **245365**

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(L3) **CERENITY - MARIAN OF ST PAUL LLC**
(L4) **200 EARL STREET**
(L5) **SAINT PAUL, MN** (L6) **55106**

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1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

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6. DATE OF SURVEY **10/21/2021** (L34)

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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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FISCAL YEAR ENDING DATE: (L35)
06/30

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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Maudeline St. Jean, HFE NE II 12/01/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/03/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :

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11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

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04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 16, 2021

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

RE: CCN: 245365
Cycle Start Date: October 21, 2021

Dear Administrator:

On October 21, 2021, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 21, 2022 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:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
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 10/21/2021

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 10/18/21 to 10/21/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 10/18/21 to 10/21/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: MN57374 H5365048C, however NO deficiencies were cited due to actions implemented by the facility prior to survey. MN76339 H5365052C, however NO deficiencies were cited due to actions implemented by the facility prior to survey. MN53664 H5365053C, however NO deficiencies were cited due to actions implemented by the facility prior to survey. MN 57394 H5365055C, however NO deficiencies were cited due to actions implemented by the facility prior to survey.	F 000		

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

Electronically Signed | 11/24/2021

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 10/21/2021

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
F 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: MN77244 H5365046C MN72190 H5365047C MN68510 H5365049C MN74211 H5365050C MN68610 H5365051C MN73192 H5365054C MN71725 H5365056C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		12/1/21

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 10/21/2021

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
F 755	Continued From page 2 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure insulin pens were removed from the medication cart and not administered to 2 of 2 residents (R3, R24) found to have expired insulin pens during medication storage review. In addition, the facility failed to ensure all other expired medications were removed from the medication carts. Findings include: R3's face sheet printed 10/20/21, indicated R3 had a diagnosis of type 2 diabetes mellitus. R24's face sheet printed 10/20/21, indicated R24 had diagnosis of type 2 diabetes mellitus and vitamin D deficiency.	F 755	The insulin pens for residents R3 and R24 were removed from the cart on 10/20/2021. All expired medications were immediately removed from the identified med carts on 10/20/2021. All residents are administered insulin that is not stored longer than pharmacy recommended standards. Residents are not administered expired medications, including over-the-counter meds (OTCs). Licensed staff and trained medication aides (TMAs) were re-educated on the facility□s policy regarding med administration/storage. Additionally, these staff completed a post-test competency evaluation. The facility reviewed their protocol/practice for med cart auditing and made adjustments; a new system was	

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 10/21/2021

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
F 755	Continued From page 3 R3's physician orders indicated Novolog Flexpen U-100 Insulin (insulin aspart u-100) per sliding scale (based on blood glucose level); subcutaneous three times a day (TID). R3's orders further indicated vitamin D-3 was discontinued on 7/1/21. R24's physician orders indicated Lantus Solostar U-100 Insulin (insulin glargine) insulin pen 14 units; subcutaneous once a day for blood glucose less than 400 and greater than 70. R24's orders further indicated Lantus Solostar U-100 Insulin (insulin glargine) 26 units; subcutaneous once a day for blood glucose less than 400 and greater than 70. During review of the first medication cart on the 5th floor on 10/20/21, at 10:39 a.m. with registered nurse (RN)-C, R24's Lantus insulin pen was labeled as removed from refrigerator and opened on 9/18/21. R24's Vitamin D3 had an expiration date 8/2021. During review of the second medication cart on 5th floor on 10/20/21, at 11:13 a.m. with licensed practical nurse (LPN)-A, R3's Aspart insulin pen was labeled as removed from refrigerator and opened 9/15/21. During review of medication cart on 3rd floor on 10/20/2, at 11:42 a.m. with RN-D, the following stock medications were found with their respective expiration dates: Geri-tussin expiration 9/2021 Vitamin D3 expiration 9/2021 Loperamide AD (anti-diarrhea) 2/2021 When interviewed on 10/20/21, at 10:39 a.m. RN-C stated, "We look at the expiration prior to	F 755	implemented. The NOC shift nurse on Wednesday nights is responsible for auditing the cart(s) on their floor to ensure that any expired medications are removed. The nurse is responsible for filling out an audit form after the completion of this required task and turn it into the nurse manager. The Nurse Managers will audit the med carts weekly for 12 weeks to ensure compliance has been achieved and sustained. Results from the audits will be reviewed by the QAPI team for input/suggestions.	

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	245365	A. BUILDING _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY - MARIAN OF ST PAUL LLC	**200 EARL STREET SAINT PAUL, MN 55106**

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F 755	Continued From page 4	F 755		

administering and if it is out of date, it is discarded and not given."

When interviewed on 10/20/21, at 12:02 p.m. RN-E stated pharmacy would look for expired medications in the carts at the beginning of every month while she (RN-E) inspected the medication carts at the end of every month. RN-E stated not aware that any resident had used the Geri-tussin for quite some time and that residents would be prescribed the Vitamin D3 and Loperamide rather than receive stock medication. Therefore, RN-E did not believe any of the expired medications found in the medication cart on 3rd floor had been used past their expiration dates. RN-E further stated Lantus and Aspart insulin pens were good at room temperature for one month and could not state any consequences if used beyond the expiration date.

When interviewed on 10/20/21, at 12:55 p.m. LPN-B reviewed the Omnicare reference guide and confirmed Lantus and Aspart insulin pens were only good for 28 days at room temperature. LPN-B further stated the nurses and TMAs (trained medication aide) should check expiration dates prior to administering all medications and should not administer expired medications. LPN-B further stated 'date opened and removed from the refrigerator' date should be checked just like an expiration date.

When interviewed on 10/20/21, at 1:57 p.m. LPN-B looked at R3's medication administration record (MAR) in the electronic health record (EHR) and confirmed R3 received the following doses of Aspart insulin: 2 doses on 10/14/21, 1 dose on 10/16/21, 1 dose on 10/17/21, 3 doses on 10/19/21 and 1 dose on 10/20/21. LPN-B

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F 755	Continued From page 5 further confirmed R24 received the following doses of Lantus insulin according the R24's MAR in the EHR: 2 doses on 10/17/21, 2 doses on 10/18/21, 2 doses on 10/19/21 and 1 dose on 10/20/21. When interviewed on 10/20/21, at 2:18 p.m. regional nurse consultant (RNC) stated the expectation was that once an insulin pen was removed from the refrigerator and opened, they would start counting 28 days. RNC further stated if the insulin pen was not used up within the 28 days, it would be discarded and not used as it would be expired past 28 days. When interviewed via email exchange on 10/21/20, pharmacist provided the guidelines for insulin storage indicating 28 days was the typical expiration for insulin pens. The pharmacist further stated, "If blood sugars remained in their normal range there is no problem. The expiration dates are very conservative and take into account the worse storage, i.e., in a patient's kitchen, for example." The facility provided medication storage policy - Insurance Storage Recommendations, dated March 2020, indicated Insulin Aspart cartridge or pen was good for 28 days when opened and stored at room temperature. Further the policy indicated Lantus pen was also good for 28 days when opened and stored at room temperature. The facility policy Medication Administration dated 2/2019, indicated staff would check expiration dates prior to administering medications.	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/1/21

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F 880	Continued From page 6 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 7 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure shared medical equipment was cleaned and disinfected for 11 of 11 residents (R23, R50, R49, R27, R2, R24, R15, R57, R59, R30, R9) reviewed for shared medical equipment use. This had the potential to affect all 24 residents who resided on the fifth floor unit. Findings include: R23's Face Sheet printed on 10/21/21, indicated	F 880	The facility□s Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, and Governing Body oversight conducted a root cause analysis (RCA) on 11/24/2021 and identified the problem that resulted in this deficiency. Subsequent re-education and planned audits were implemented to prevent recurrence. The Executive Director and Director of	

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F 880	Continued From page 8 R23's diagnoses included acute respiratory failure with hypoxia, diabetes mellitus and chronic kidney disease stage 1 through stage 4. R50's Face Sheet printed on 10/21/21, indicated R50's diagnoses included acute systolic (congestive) heart failure, hypertension, cerebral infarction, and type 2 diabetes mellitus. R49's Face Sheet printed on 10/21/21, indicated R49's diagnoses included chronic obstructive pulmonary disease, chronic diastolic congestive heart failure, dermatitis, allergic rhinitis, and chronic respiratory failure with hypoxia. R27's Face Sheet printed on 10/21/21, indicated R27's diagnoses included chronic obstructive pulmonary disease, chronic kidney disease and unspecified asthma. R2's Face Sheet printed on 10/21/21, indicated R2's diagnoses included sepsis, unspecified organism, diabetes mellitus with hyperglycemia, unspecified asthma, and cerebral vascular accident. R24's Face Sheet printed on 10/21/21, indicated R24's diagnoses included allergic rhinitis, Type 2 diabetes mellitus with diabetic polyneuropathy, acute pulmonary edema, and Presence of aortocoronary bypass graft. R15's Face Sheet printed on 10/21/21, indicated R15's diagnoses included presence of prosthetic heart valve, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease. R57's Face Sheet printed on 10/21/21, indicated	F 880	Nursing reviewed policies and procedures regarding disinfecting multiuse/shared equipment/items and to ensure they met the CDC guidance for disinfection in healthcare facilities and follow disinfectant product manufacturer directions for use including contact time. The Director of Nursing and/or the Infection Preventionist trained all staff responsible for resident care equipment on the facility policies/procedures for proper disinfection, including following manufacturer directions for use. Each staff person will demonstrate competency at the conclusion of the training; this will be documented. The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance. The Director of Nursing, Infection Preventionist or designee will review the results of the audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.	

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F 880	Continued From page 9	F 880		

R57's diagnoses included sepsis due to escherichia coli (E.Coli), Long term (current) use of antibiotics, urinary tract infection, and severe sepsis with septic shock.

R59's Face Sheet printed on 10/21/21, indicated R59's diagnoses included Acute and chronic respiratory failure, chronic obstructive pulmonary disease, stage 1 through stage 4 chronic kidney disease, and history of recurrent pneumonia.

R30's Face Sheet printed on 10/21/21, indicated R30's diagnoses included diabetes mellitus, chronic bronchitis, and atherosclerotic heart disease.

R9's Face Sheet printed on 10/21/21, indicated R9's diagnoses included wedge compression fracture of first lumbar vertebra, irritable bowel syndrome with diarrhea, and acute respiratory disease.

During observation on 10/18/21, from 3:00 p.m to 3:22 p.m. nursing assistant (NA)-A exited R23's room with a roller blood pressure (BP) equipment. There was an oxygen saturation device also attached to BP equipment. There was an unattached thermometer also in the storage bin on the BP equipment. NA-A went into R50's room and attached the BP cuff and completed BP check and left R50's room with BP equipment. No sanitizing was observed and there were no sanitizing wipes noted in the BP storage bin. NA-A then went into R49's room and checked R49's BP and went to the following resident's rooms and checked BP, oxygen saturations, and temperatures (R27, R2, R24, R15, R57, R59, R30). NA-A then went into the common area and checked oxygen saturations and temperatures on

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F 880	Continued From page 10	F 880		

three unidentified residents. NA-A then went and checked R9's temperature and oxygen saturations who also sat in the common area.

During observation on 10/18/21, at 3:22 p.m. NA-A took the BP equipment and plugged it into the wall in the hallway. No observation of sanitizing or disinfecting noted.

During interview on 10/18/21, at 3:25 p.m. NA-A verified she did not clean BP and vital equipments between residents during vitals check observation, and also stated the BP equipment was usually cleaned at the start of the shift and also at the end of the shift.

During interview on 10/21/21, at 9:11 a.m. infection preventionist registered nurse (RN)-F stated it was the expectations that staff sanitized BP and vital equipment between residents during vitals checks.

During interview on 10/21/21, at 2:07 p.m. regional nurse specialist (RNC)-B stated staff were expected to use the facility approved disinfecting wipes and to sanitize BP and vital equipment between resident use.

The facility Resident Care Equipment Policy dated 6/2017, indicated the purpose of the policy was to ensure that reusable equipment was not used for the care of another resident until it had been cleaned and reprocessed appropriately. Staff were to disinfect reusable equipment between resident uses using an EPA approved disinfectant.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245365	A. BUILDING: _____ B. WING _____	10/21/2021

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CERENITY - MARIAN OF ST PAUL LLC	**200 EARL STREET SAINT PAUL, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (CMS-10055) was provided timely upon termination of Medicare A benefits to 1 of 3 residents (R5) reviewed for liability notices. Findings include: The facility's Daily Census Report dated 10/18/21, indicated R5 payer was private pay. The facility completed CMS-20052 Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review Form and identified R5's Medicare Part A skilled services start date was 7/22/21, and last covered day of Part A service was documented as 8/12/21. The facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The facility did not provide the Skilled Nursing Facility

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1

Advanced Beneficiary Notice of Non-Coverage CMS -10055 to R5 or family representative and indicated the reason why not as the resident stayed at the facility.

R5's required Notice of Medicare Non-Coverage (CMS-10123) indicated a coverage end date of 8/12/01, {SIC} and was signed and dated by R5's power of attorney (POA) on 8/10/21.

During an interview on 10/21/21, at 10:16 a.m. registered nurse (RN)-B stated typically he would provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (CMS-10055) to the residents or their representative and discuss their right to appeal and inform them what the estimated cost would be, however he did not provide R5 or her representative the notice due to oversight and being very busy recently.

The facility Medicare Beneficiary Notices Policy updated 11/2017, in an effort to prevent fraud, waste and abuse and ensure proper reimbursement, the facility will provide beneficiary notices according to Medicare guidelines. SNF Advance Beneficiary Notice (SNFABN) (CMS-10055) will be provided when the beneficiary met the technical requirements but did not need daily skilled services, Part A services were ending and the beneficiary was to remain in the facility or when the need for daily skilled service was no longer necessary, but they will receive Part B therapy services, issue the SNFABN (CMS-10055) or one of the 5 approved denial letters. The notice must be issued far enough in advance of delivering potentially non-covered items or services to allow sufficient time for the beneficiary to consider all available options.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	**10/21/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/21/2021. At the time of this survey, Cerenity Care Center on Marian was found 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, the Health Care Facilities Code. 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. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

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

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.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 16, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: KPJR11

Dear Administrator:

The above facility was surveyed on October 18, 2021 through October 21, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00354	A. BUILDING: _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY - MARIAN OF ST PAUL LLC	200 EARL STREET SAINT PAUL, MN 55106

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/18/21 to 10/21/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000	*****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has	

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: MN57374 H5365048C, however NO licensing orders were issued MN76339 H5365052C, however NO licensing orders were issued. MN53664 H5365053C, however NO licensing orders were issued. MN 57394 H5365055C however NO licensing orders were issued. The following complaint were found to be UNSUBSTANTIATED: MN77244 H5365046C MN72190 H5365047C MN68510 H5365049C MN74211 H5365050C MN68610 H5365051C MN73192 H5365054C MN71725 H5365056C	2 000	been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.	
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		12/1/21

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21385	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure shared medical equipment was cleaned and disinfected for 11 of 11 residents (R23, R50, R49, R27, R2, R24, R15, R57, R59, R30, R9) reviewed for shared medical equipment use. This had the potential to affect all 24 residents who resided on the fifth floor unit. Findings include: R23's Face Sheet printed on 10/21/21, indicated R23's diagnoses included acute respiratory failure with hypoxia, diabetes mellitus and chronic kidney disease stage 1 through stage 4. R50's Face Sheet printed on 10/21/21, indicated R50's diagnoses included acute systolic (congestive) heart failure, hypertension, cerebral infarction, and type 2 diabetes mellitus. R49's Face Sheet printed on 10/21/21, indicated R49's diagnoses included chronic obstructive pulmonary disease, chronic diastolic congestive heart failure, dermatitis, allergic rhinitis, and chronic respiratory failure with hypoxia. R27's Face Sheet printed on 10/21/21, indicated R27's diagnoses included chronic obstructive pulmonary disease, chronic kidney disease and unspecified asthma. R2's Face Sheet printed on 10/21/21, indicated R2's diagnoses included sepsis, unspecified organism, diabetes mellitus with hyperglycemia, unspecified asthma, and cerebral vascular accident.	21385	Corrected	

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R24's Face Sheet printed on 10/21/21, indicated R24's diagnoses included allergic rhinitis, Type 2 diabetes mellitus with diabetic polyneuropathy, acute pulmonary edema, and Presence of aortocoronary bypass graft.

R15's Face Sheet printed on 10/21/21, indicated R15's diagnoses included presence of prosthetic heart valve, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease.

R57's Face Sheet printed on 10/21/21, indicated R57's diagnoses included sepsis due to escherichia coli (E.Coli), Long term (current) use of antibiotics, urinary tract infection, and severe sepsis with septic shock.

R59's Face Sheet printed on 10/21/21, indicated R59's diagnoses included Acute and chronic respiratory failure, chronic obstructive pulmonary disease, stage 1 through stage 4 chronic kidney disease, and history of recurrent pneumonia.

R30's Face Sheet printed on 10/21/21, indicated R30's diagnoses included diabetes mellitus, chronic bronchitis, and atherosclerotic heart disease.

R9's Face Sheet printed on 10/21/21, indicated R9's diagnoses included wedge compression fracture of first lumbar vertebra, irritable bowel syndrome with diarrhea, and acute respiratory disease.

During observation on 10/18/21, from 3:00 p.m to 3:22 p.m. nursing assistant (NA)-A exited R23's room with a roller blood pressure (BP) equipment. There was an oxygen saturation

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device also attached to BP equipment. There was an unattached thermometer also in the storage bin on the BP equipment. NA-A went into R50's room and attached the BP cuff and completed BP check and left R50's room with BP equipment. No sanitizing was observed and there were no sanitizing wipes noted in the BP storage bin. NA-A then went into R49's room and checked R49's BP and went to the following resident's rooms and checked BP, oxygen saturations, and temperatures (R27, R2, R24, R15, R57, R59, R30). NA-A then went into the common area and checked oxygen saturations and temperatures on three unidentified residents. NA-A then went and checked R9's temperature and oxygen saturations who also sat in the common area.

During observation on 10/18/21, at 3:22 p.m. NA-A took the BP equipment and plugged it into the wall in the hallway. No observation of sanitizing or disinfecting noted.

During interview on 10/18/21, at 3:25 p.m. NA-A verified she did not clean BP and vital equipments between residents during vitals check observation, and also stated the BP equipment was usually cleaned at the start of the shift and also at the end of the shift.

During interview on 10/21/21, at 9:11 a.m. infection preventionist registered nurse (RN)-F stated it was the expectations that staff sanitized BP and vital equipment between residents during vitals checks.

During interview on 10/21/21, at 2:07 p.m. regional nurse specialist (RNC)-B stated staff were expected to use the facility approved disinfecting wipes and to sanitize BP and vital equipment between resident use.

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21385	Continued From page 5 The facility Resident Care Equipment Policy dated 6/2017, indicated the purpose of the policy was to ensure that reusable equipment was not used for the care of another resident until it had been cleaned and reprocessed appropriately. Staff were to disinfect reusable equipment between resident uses using an EPA approved disinfectant. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program and ensure shared medical equipment is cleaned and disinfected appropriate between resident use. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure insulin pens were removed from the medication cart and not	21620	Corrected	12/1/21

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administered to 2 of 2 residents (R3, R24) found to have expired insulin pens during medication storage review. In addition, the facility failed to ensure all other expired medications were removed from the medication carts.

Findings include:

R3's face sheet printed 10/20/21, indicated R3 had a diagnosis of type 2 diabetes mellitus.

R24's face sheet printed 10/20/21, indicated R24 had diagnosis of type 2 diabetes mellitus and vitamin D deficiency.

R3's physician orders indicated Novolog Flexpen U-100 Insulin (insulin aspart u-100) per sliding scale (based on blood glucose level); subcutaneous three times a day (TID). R3's orders further indicated vitamin D-3 was discontinued on 7/1/21.

R24's physician orders indicated Lantus Solostar U-100 Insulin (insulin glargine) insulin pen 14 units; subcutaneous once a day for blood glucose less than 400 and greater than 70. R24's orders further indicated Lantus Solostar U-100 Insulin (insulin glargine) 26 units; subcutaneous once a day for blood glucose less than 400 and greater than 70.

During review of the first medication cart on the 5th floor on 10/20/21, at 10:39 a.m. with registered nurse (RN)-C, R24's Lantus insulin pen was labeled as removed from refrigerator and opened on 9/18/21. R24's Vitamin D3 had an expiration date 8/2021.

During review of the second medication cart on 5th floor on 10/20/21, at 11:13 a.m. with licensed

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practical nurse (LPN)-A, R3's Aspart insulin pen was labeled as removed from refrigerator and opened 9/15/21.

During review of medication cart on 3rd floor on 10/20/2, at 11:42 a.m. with RN-D, the following stock medications were found with their respective expiration dates:
Geri-tussin expiration 9/2021
Vitamin D3 expiration 9/2021
Loperamide AD (anti-diarrhea) 2/2021

When interviewed on 10/20/21, at 10:39 a.m. RN-C stated, "We look at the expiration prior to administering and if it is out of date, it is discarded and not given."

When interviewed on 10/20/21, at 12:02 p.m. RN-E stated pharmacy would look for expired medications in the carts at the beginning of every month while she (RN-E) inspected the medication carts at the end of every month. RN-E stated not aware that any resident had used the Geri-tussin for quite some time and that residents would be prescribed the Vitamin D3 and Loperamide rather than receive stock medication. Therefore, RN-E did not believe any of the expired medications found in the medication cart on 3rd floor had been used past their expiration dates. RN-E further stated Lantus and Aspart insulin pens were good at room temperature for one month and could not state any consequences if used beyond the expiration date.

When interviewed on 10/20/21, at 12:55 p.m. LPN-B reviewed the Omnicare reference guide and confirmed Lantus and Aspart insulin pens were only good for 28 days at room temperature. LPN-B further stated the nurses and TMAs (trained medication aide) should check expiration

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dates prior to administering all medications and should not administer expired medications. LPN-B further stated 'date opened and removed from the refrigerator' date should be checked just like an expiration date.

When interviewed on 10/20/21, at 1:57 p.m. LPN-B looked at R3's medication administration record (MAR) in the electronic health record (EHR) and confirmed R3 received the following doses of Aspart insulin: 2 doses on 10/14/21, 1 dose on 10/16/21, 1 dose on 10/17/21, 3 doses on 10/19/21 and 1 dose on 10/20/21. LPN-B further confirmed R24 received the following doses of Lantus insulin according the R24's MAR in the EHR: 2 doses on 10/17/21, 2 doses on 10/18/21, 2 doses on 10/19/21 and 1 dose on 10/20/21.

When interviewed on 10/20/21, at 2:18 p.m. regional nurse consultant (RNC) stated the expectation was that once an insulin pen was removed from the refrigerator and opened, they would start counting 28 days. RNC further stated if the insulin pen was not used up within the 28 days, it would be discarded and not used as it would be expired past 28 days.

When interviewed via email exchange on 10/21/20, pharmacist provided the guidelines for insulin storage indicating 28 days was the typical expiration for insulin pens. The pharmacist further stated, "If blood sugars remained in their normal range there is no problem. The expiration dates are very conservative and take into account the worse storage, i.e., in a patient's kitchen, for example."

The facility provided medication storage policy - Insurance Storage Recommendations, dated

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21620	Continued From page 9 March 2020, indicated Insulin Aspart cartridge or pen was good for 28 days when opened and stored at room temperature. Further the policy indicated Lantus pen was also good for 28 days when opened and stored at room temperature. The facility policy Medication Administration dated 2/2019, indicated staff would check expiration dates prior to administering medications. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		