Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2022

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

RE: CCN: 245255
Cycle Start Date: August 11, 2022

Dear Administrator:

On September 9, 2022, we notified you a remedy was imposed. On September 16, 2022 the Minnesota Department of Health 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 September 12, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 11, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 24, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 11, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 12, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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, 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

Electronically delivered
August 24, 2022

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

RE: CCN: 245255
Cycle Start Date: August 11, 2022

Dear Administrator:

On August 11, 2022, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 11, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 11, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/10/22 and 8/11/22, a standard abbreviated survey was conducted at your facility. 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 complaint was found to be SUBSTANTIATED: H52553799C (MN85829), with deficiencies cited at F760. The following complaints were found to be UNSUBSTANTIATED: H52553628C (MN85558), H52553772C (MN85685), and H52553848C (MN85642) however, related deficiencies were cited at F609 and F610. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		9/2/22

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

Electronically Signed | 09/02/2022

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 609	Continued From page 1 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report an injury of unknown source to the state agency for 1 of 3 (R1) residents reviewed. Findings Include: R1's admission Minimum Data Set (MDS) dated 7/14/22, indicated R1 had a diagnosis of cerebral infarction (stroke) due to embolism of the basilar artery (blood clot in the artery which provides blood to the brain) and was on anticoagulant medication. The MDS did not indicate a Brief Inventory of Mental Status (BIMS) as R1 refused the assessment. R1 needed extensive	F 609	F609 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • The resident was transferred to the hospital on 7/29/22 for an unrelated change in condition. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: • All residents have the potential to affected by the same deficient practice; no	

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F 609	Continued From page 2 assistance with bed mobility, transfers, and activities of daily living (ADL's) Physical Therapy Encounter Note dated 7/28/22, indicated R1 had new bruising along right lateral side of unknown etiology, though nursing believes it might be due to holding on tightly to the bed railing. Discussed findings with nursing. They reported he has failing kidney values and an international normalized ratio (INR) x4 normal which may explain bruising and pain. BIMS assessment was completed on 8/8/22, indicating R1 had a score of 11, which indicated moderate cognitive impairment. During observation on 8/10/22, at 9:08 a.m. R1 had a light bluish bruise on his right abdominal side below the rib cage to the pelvic bone. R1 reported he had the bruise for about a week or so. He stated the staff is rough. He could indicate a particular event which caused the bruised. "I assume it is from how they pull on me when they move me." R1 denied being abused or any falls. During interview on 8/10/22, at 4:17 p.m. physical therapist (PT)-A reported observing the bruise the day before R1 went to the hospital. He did not feel it was from the bedrail with the way the bedrail was situated. He stated, "I would say we don't know what happened." He reported the bruise to licensed practical nurse (LPN)-B immediately. During interview on 8/10/22, at 4:31 p.m. LPN-B verified that PT-A reported the bruise to her, and she reported it on to the nurse manager, who is registered nurse (RN)-C. LPN-B stated R1 was	F 609	similar findings and/or negative outcomes have been identified. What measures or systemic changes will be made to ensure the deficient practice will not recur: • Interdisciplinary Team (IDT) and Licensed Nurses were educated on the requirements of F609, Reporting of Alleged Violations. Specifically, the education will focus on the facility's responsibility to ensure any injury of unknown source is immediately reported to the Administrator and/or DON and respective State Agency as indicated. How will the facility monitor its performance to make sure the solutions are sustained? • Administrator or designee will perform random audits, in the form of resident and staff interviews, weekly x 4, bi-weekly x 2, and monthly x 1 to ensure ongoing and sustained compliance with this alleged deficient practice. • Any adverse findings will be immediately reported to the Administrator and/or DON, investigated and reported to the State Agency as deemed necessary. • Results of the audits will be reported to the Quality Assessment and Assurance (QAA) Committee for further review and consideration for additional corrective measures until compliance is sustained. Date of correction: • 9/22/22	

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F 609	Continued From page 3 lethargic that morning and some lab results came in as being critical, so the nurse practitioner (NP) was notified about the lab results and R1's lethargy and was ordered to send him to the hospital. LPN-B stated, "I did not start an event on the bruise." During interview on 8/10/22, at 4:42 p.m. RN-C verified that LPN-B told her about the bruise and RN-C did witness the bruise. She reported the NP was notified about R1 being lethargic, confused and having an increased INR and an increased creatinine level. She stated she did report the bruise to the NP with the report and R1 was ordered to go to the hospital. RN-C stated she knows the bruise was not there the day before as she asked the nursing assistant. RN-C could not recall which nursing assistant she asked about the bruise, and this was the first notice of the bruise on 7/28/22. The LPN did not start an event report on the bruise. During interview on 8/11/22, at 9:45 a.m. RN-D stated that on the night of 7/27/22, R1 was found with his legs hanging over the side of the bed and pulling on the side rail. R1 and the nursing assistant lowered him to the floor and lifted him back into bed with a transfer belt. She stated since there was not a fall, she did not do a full skin assessment and did not notice a large bruise on his abdomen. During interview on 8/11/22, at 11:30 a.m. the director of nursing (DON) reported she was unaware that staff had noticed a large bruise on R1. The DON verified that there were no progress notes or an assessment on the bruise and there was not an event/investigation initiated.	F 609		

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F 609	Continued From page 4 During interview on 8/11/22, at 12:36 p.m. the NP stated that he saw R1 on 7/28/22, and did not notice any bruising on the abdomen. He stated that nursing had called him regarding his lab reports, mental status and she did mention the bruise. R1 was sent to the hospital. NP stated, "I don't think we can say how he got it; it could have been because of his high INR with blood slowly leaking into the area." He reported he did notice the fading bruise this a.m. when he saw him and the area seemed to be healing and was light in color and nontender. Abuse Prevention Plan dated 7/21/22, indicated any person with the knowledge of suspicion of suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation must report immediately. Any injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was not observed by any person, or the source could not be explained, and the injury is suspicious because the extent of the injury or the location or the number or injuries observed at one time.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		9/2/22

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F 610	Continued From page 5 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate an injury of unknown origin for 1 of 3 (R1) residents reviewed. R1 was found to have a large bruise on his abdomen that the facility failed to initiate an investigation. Findings include: R1's admission Minimum Data Set (MDS) dated 7/14/22, indicated R1 had a diagnosis of cerebral infarction (stroke) due to embolism of the basilar artery (blood clot in the artery which provides blood to the brain) and was on anticoagulation medication. The MDS did not indicate a Brief Inventory of Mental Status (BIMS) as R1 refused the assessment. R1 needed extensive assistance with bed mobility, transfers, and activities of daily living (ADL's) Physical Therapy Encounter Note dated 7/28/22, indicated R1 had new bruising along right lateral side of unknown etiology, though nursing believes it might be due to holding on tightly to the bed railing. Discussed findings with nursing. They reported he has failing kidney values and an international normalized ratio (INR) x4 normal which may explain bruising and pain.	F 610	F610 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • The resident was transferred to the hospital on 7/29/22 for an unrelated change in condition. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: • All residents have the potential to affected by the same deficient practice; no similar findings and/or negative outcomes have been identified. What measures or systemic changes will be made to ensure the deficient practice will not recur: • Interdisciplinary Team and Licensed Nurses will be educated on the requirements of F610, Investigating of an injury of unknown source. Specifically, the education will focus on the facility's responsibility to ensure any injury of unknown source is thoroughly investigated and reviewed.	

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F 610	Continued From page 6 BIMS assessment was completed on 8/8/22, indicating R1 had a score of 11, which indicated moderate cognitive impairment. During observation on 8/10/22, at 9:08 a.m. R1 had a light bluish bruise on his right abdominal side below the rib cage to the pelvic bone. R1 reported he had the bruise for about a week or so. He stated the staff is rough. He could indicate a particular event which caused the bruised. "I assume it is from how they pull on me when they move me." R1 denied being abused or any falls. During interview on 8/10/22, at 4:17 p.m. physical therapist (PT)-A reported observing the bruise the day before R1 went to the hospital. PT-A stated he did not feel it was from the bedrail with the way the bedrail was situated. He stated, "I would say we don't know what happened." He reported the bruise to LPN-B immediately. During interview on 8/10/22, at 4:31 p.m. LPN-B verified that PT-A reported the bruise to her, and she reported it on to the nurse manager, who is registered nurse (RN)-C. LPN-B stated R1 was lethargic that morning and some lab results came in as being critical, so the nurse practitioner (NP) was notified about the lab results and R1 lethargy and was ordered to send him to the hospital. LPN-B stated, "I did not start an event on the bruise." During interview on 8/10/22, at 4:42 p.m. RN-C verified that LPN-B told her about the bruise and RN-C did witness the bruise. She reported the NP was notified about R1 being lethargic, confused and having an increased INR and an increased creatinine level. She stated she did	F 610	• A monitoring log will be developed and completed by the DON or designee during the daily clinical meeting to ensure all areas of bruising have been investigated, source identified, and the resident's care plan updated. How will the facility monitor its performance to make sure the solutions are sustained? • The monitoring log will be reviewed by the Administrator or designee 5 x week x 4 weeks; 2 x week x 3 weeks; 1 x weekly x 1 month to ensure ongoing compliance. • Results from the monitoring will be reported to the Quality Assessment and Assurance (QAA) Committee for further review and consideration for additional corrective measures until compliance is sustained. Date of correction: • 9/22/22	

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F 610	Continued From page 7 report the bruise to the NP with the report and R1 was ordered to go to the hospital. RN-C stated she knows the bruise was not there the day before as she asked the nursing assistant. She could not recall which nursing assistant she asked about the bruise, and this was the first notice of the bruise on 7/28/22. The LPN did not start an event on the bruise. During interview on 8/11/22, at 9:45 a.m. RN-D stated that on the night of 7/27/22, R1 was found with his legs hanging over the side of the bed and pulling on the side rail. R1 and the nursing assistant lowered him to the floor and lifted him back into bed with a transfer belt. She stated since there was not a fall, she did not do a full skin assessment, but did not notice a large bruise on his abdomen. During record review on 8/11/22, at 10:07 a.m. there were no notes in the nursing progress notes or any skin assessments completed indicating the bruise. The facility did not have an investigation file initiated. During interview on 8/11/22, at 11:30 a.m. the director of nursing (DON) reported she was unaware that staff had noticed a large bruise on R1. The DON verified that there were no progress notes or an assessment on the bruise and there was not an event/investigation initiated. Abuse Prevention Plan dated 7/21/22, indicated any person with the knowledge of suspicion of suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation must report immediately. All events will be investigated whether they cause injury or harm or no injury or harm. Any injury should be classified	F 610		

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(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 610	Continued From page 8 as an "injury of unknown source' when both of the following conditions are met: The source of the injury was not observed by any person, or the source could not be explained, and the injury is suspicious because the extent of the injury or the location or the number or injuries observed at one time.	F 610		
F 760 SS=D	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 that 1 of 3 (R1) residents was free from a significant medication error. R1 was given 5 mg of Coumadin (a blood thinner) instead of 0.5 mg. This error caused his international normalized ratio (INR) to be 6.53 which is considered a critical lab value. This lab value put R1 at potential risk for severe bleeding having the potential to lead to death. Findings Include: R1's admission Minimum Data Set (MDS) dated 7/14/22, indicated R1 had a diagnosis of cerebral infarction (stroke) due to embolism of the basilar artery (blood clot in the artery which provides blood to the brain) and was on anticoagulant medications. The MDS did not indicate a Brief Inventory of Mental Status (BIMs) as R1 refused the assessment. BIMs assessment was completed on 8/8/22, indicating R1 had a score of 11, which indicated	F 760	F760 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • When error was identified the provider was immediately notified and orders obtained to hold the Coumadin and administer Vitamin K. The resident had no negative outcomes. • The nurse involved with the transcription error was provided 1:1 education. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: • All residents on blood thinning medications have the potential to be affected by the same deficient practice; all orders of residents on blood thinning	9/2/22

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	245255	A. BUILDING _____ B. WING _____	C 08/11/2022

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F 760	Continued From page 9 moderate cognitive impairment. Warfarin (Coumadin) Monitoring Form dated 8/2/22, indicated INR was 2.40. The form indicated a dose change from 1 mg to .5 mg [sic] Comments were .5 mg [sic] tonight and tomorrow. Next INR draw 8/5/22. Warfarin Monitoring Form dated 8/5/22, indicated INR was 2.40 the form indicated no dosage change and Coumadin dose of 5 mg for Friday, Saturday, and Sunday. The next INR was to be 8/8/22. Warfarin Monitoring Form dated 8/8/22, indicated INR was 6.53. Dose changed to hold Coumadin and administer Vitamin K. INR to be drawn on 8/9/22. Nursing progress note dated 8/8/22, at 3:51 p.m. indicated INR result came back (INR=6.53), Nurse Practitioner (NP) updated, new orders received, hold Coumadin tonight 8/8/22, re-check INR in the morning 8/9/22, Vitamin K 2.5 mg po now. He is alert and oriented x2, he is stable, no signs of bleeding or bruising noted. Nursing progress note dated 8/9/22, at 2:23 p.m. indicated INR was 3.47 NP was updated and ordered to hold Coumadin today 8/9/22, and recheck INR 8/10/22. The medical record did not indicate a medication error occurred and no interventions, assessment or monitoring were put into place. R1 had received higher doses of Coumadin than ordered. During interview on 8/10/22, at 9:08 a.m. R1 reported that staff did report to him that a med	F 760	medications were reviewed and no additional errors were identified. What measures or systemic changes will be made to ensure the deficient practice will not recur: • The Regional nurse will provide education to the DON on the expectations related to monitoring of blood thinners and investigating medication errors. • The DON or facility educator will provide education to all licensed nurses and medication aides (TMAs) on verifying and transcribing blood thinner orders and use of the Coumadin and PT/INR log. The education will also include the process for what to do if a medication error occurs. • All new Coumadin orders and any associated monitoring orders will be reviewed during the daily clinical meeting and documented on a log as reviewed and confirmed. Any discrepancies will immediately be rectified per the facilities medication error policy. How will the facility monitor its performance to make sure the solutions are sustained? • The Coumadin order log will be reviewed by the Administrator or designee 5 x week x 4 weeks; 2 x week x 3 weeks; 1 x weekly x 1 month to ensure ongoing compliance. • Results from the monitoring will be reported to the Quality Assessment and Assurance (QAA) Committee for further review and consideration for additional corrective measures until compliance is sustained	

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F 760	Continued From page 10 error had occurred with his "blood thinning" medication. He stated that is all he knew and that he had not been taking it for a few days. He denied any education based on the error. During interview on 8/10/22, at 1:16 p.m. registered nurse (RN)-A reported he thought the order was 5 mg per the Warfarin Monitoring Form, as the nurse before him wrote the order as .5 mg and there was not a zero in front of the .5. and added, "That was misleading to me." "I told the [NP] on the phone when I was calling to get new orders that the previous order was 5 milligrams, and her order was to continue with the same dose." The order was not clarified over the phone as 0.5 mg or 5 mg, just to keep the order the same. RN-A denied checking the Electronic Medication Administration Record (EMAR) to verify what the previous dose had been. RN-A reported he was the nurse working from 8/5/22 - 8/7/22 and 5 mg of Coumadin was given all three nights. He reported finding out about the error on 8/8/22, when he worked his p.m. shift. The NP had gotten the critical lab results and the NP was questioning the dosage. The facility did not perform any education with RN-A. During interview on 8/10/22, at 2:32 p.m. RN-B reported that she does recall verifying the Coumadin order at 5 mg She reported that if was supposed to have been 0.5 mg the previous order would have said 0.5 mg not .5 mg. She reported that she verified on the Coumadin Monitoring Sheet and the order form sent to the pharmacy that the dose was 5 mg but denied looking at the EMAR to see what the previous order had been. During interview on 8/10/22, at 3:15 p.m. licensed practical nurse (LPN)-B reported she was the	F 760	Date of correction: • 9/22/22	

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F 760	Continued From page 11 nurse who wrote the order as .5 on the Warfarin Monitoring Form. She stated she had heard there had been a Coumadin error on R1 but did not know any specifics. She reported she writes 0.5 or .5. She has never been taught that there is a specific way to write out a dosage. The facility did not contact her following the incident. During interview on 8/11/22, at 11:30 a.m. with the director of nursing (DON) verified LPN-B should have placed a zero before the 0.5 mg Coumadin order on the the Warfarin Monitoring Sheet. The DON denied contacting LPN-B following the medication error and denied ever educating staff that a zero needed to be placed before a period on an order if no number value is placed in that spot. A facility policy titled Administering Medications indicated the purpose was to ensure safe administration of the residents' medications. With any irregularities, appropriate notifications will be completed for clarification. A policy specific to Warfarin medication was requested, however, the facility did not provide one.	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 24, 2022

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

Re: Event ID: XIFW11

Dear Administrator:

The above facility survey was completed on August 11, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

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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 8/10/22 to 8/11/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H52553628C (MN85558), H52553772C (MN85685), H52553848C (MN85642). The following complaint was found to be SUBSTANTIATED: H52553799C (MN85829), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		