Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 25, 2025

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

RE: CCN: 245255
Cycle Start Date: May 15, 2025

Dear Administrator:

On June 5, 2025, we notified you a remedy was imposed. On June 20, 2025 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 June 17, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 20, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 5, 2025, 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 June 20, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 17, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location 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

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June 25, 2025

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

Re: Reinspection Results
Event ID: JZ2T12

Dear Administrator:

On June 20, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 15, 2025. At this time these correction orders were found corrected.

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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June 5, 2025

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

RE: CCN: 245255
Cycle Start Date: May 15, 2025

Dear Administrator:

On May 15, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G),whereby corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 20, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 20, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 20, 2025.

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

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effectiveJune 20, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

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 November 15, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an

appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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June 5, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: JZ2T11

Dear Administrator:

The above facility was surveyed on May 12, 2025 through May 15, 2025 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

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 05/15/2025

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 5/12/25 through 5/15/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52553807C (MN112647), H52554390C (MN112659), H52554389C (MN111814), H52554391C (MN111735), H52554608C (MN112977), & H52554609C (MN112997) with deficiencies cited at F689, F725, F755, F810, F842, & F867. 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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

Electronically Signed | 06/10/2025

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

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident received adequate supervision and assistance to prevent accidents for 1 of 3 residents (R4) reviewed for falls. This resulted in actual harm when R4 fell and suffered a femur fracture. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance. Findings include: R4's face sheet dated 5/16/25, identified diagnoses of Parkinson's disease (a disease of the central nervous system that affects movement), depression (persistent sadness), and anxiety (a common human emotion involving feelings of worry, nervousness, or unease). R4's Physical Therapy (PT) evaluation dated 4/22/25, identified that R4 was admitted the facility due to weakness and without further PT she would be at increased risk for falls and functional decline. R4 was modified independence with contact guard assistance (one or two hands on body to support balance or steady body) for transfers. R4's admission Minimum Data Set (MDS) dated 4/27/25, identified R4 needed supervision or touching assistance for transfers and had moderate cognitive impairment. R4's fall care plan focus dated 4/22/25, identified R4 was at risk for falls due to Parkinson's disease. Goal of will not sustain a fall related injury through review date. With interventions of	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2 education on prevention, reduction precautions per facility protocol. R4's care plan did not identify what level of transfer assistance R4 required as per the PT evaluation dated 4/22/25 nor the level of assistance that was identified on the MDS dated 4/27/25. R4's nursing assistant care sheet dated 4/22/25, identified R4 was assist x1 with gait belt and walker for transfers. R4's physician note dated 5/1/25, identified R4 was still working with therapy and is not back to her baseline strength or balance and does not feel ready to go home. R4's fall safety event dated 5/10/25 at 1:45 p.m.., identified R4 had a witnessed fall in her room during a transfer without assistance. During the transfer R4's feet became entangled in the nightstand, which caused her to lose her balance, fall, and landed on her right hip. R4 had pain in right femur area and was sent to emergency department (ED) for evaluation. R4's emergency department (ED) note dated 5/10/25, identified R4 had been seen in ED following a fall in the nursing home and had subsequent hip pain and unable to bear weight. Imaging showed moderately displaced intertrochanteric fracture of the proximal right femur. R4's hospital operative note dated 5/11/25, identified R4 underwent insertion of intramedullary nail of right femur following a fall in the nursing home. R4's interdisciplinary team (IDT) progress note	F 689		

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F 689	Continued From page 3 dated 5/12/25 at 10:12 a.m., identified review of fall on 5/10/25 that R4 was ambulating in room with a staff member present with a gait belt on, however he stepped back as resident was attempting to brush her hair near the nightstand. Staff visualized R4's feet got tangled up in the nightstand when attempting to turn, causing her to lose balance and fall. Staff member was not within close reach to catch R4 from falling. Staff interviews reveal that R4 had a history of ambulating in her room without assistance. R4 was an assist of one with a walker for transfers and ambulation prior to the fall. R4's activities of daily living care plan dated 5/12/25 was revised after her fall on 5/10/25, to include the level of staff assistance R4 required which was, limited assist of one for transfers with a gait belt and walker. R4's progress note dated 5/14/25, identified R4 returned from the hospital and was substantial/maximum assistance for all transfers. During an interview on 5/15/25 at 1:38 p.m., nursing assistant (NA)-B referenced the nursing assistant care sheets as the "care plan" that gives them direction on how to care for a resident. During an interview on 5/15/25 at 3:55 p.m., nursing assistant (NA)-D stated he was assisting R4 in her room at the time of her fall on 5/10/25. NA-D placed a gait belt on R4 and ambulated her next to the nightstand so she could brush her hair, he then left her at the nightstand and went to get her walker when she must have turned and got her feet tangled on the nightstand and fell to the ground. NA-D stated he was not standing near R4 at that time, and when she lost her	F 689		

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F 689	Continued From page 4 balance, he was not able to catch her. During an interview on 5/15/25 at 12:40 p.m., licensed practical nurse (LPN)-C stated R4's nursing assistant care sheet identified R4's transfer status of assist of one staff on admission, however R4's care plan did not identify how she was transferred until 5/12/25 after it was reviewed after the fall. During an interview on 5/15/25 at 4:36 p.m., registered nurse regional director (RNRD) stated her expectation would be for staff to transfer resident per plan of care and ensure adequate supervision is provided during the transfers to maintain safety and that any resident would have their care plans updated in a timely manner. Review of the facility's Integrated Fall Management Policy dated 9/23, identified residents with risk for falling will have interventions implemented through their resident centered plan of care. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. The following corrective actions were verified as implemented prior to the survey: 1. A four-point plan of correction was initiated on 5/12/25: a. Specific action taken for identified resident. b. Resident sent to ED for treatment. c. NA suspended pending investigation. d. Updated provider and family. e. Report filed with state agency.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 5 f. Interview of NA involved. g. Interviewed therapy. h. Interviewed like residents with no concerns identified. 2. Root cause of R4's fall identified that NA was not following the plan of care and that R4 should have been assist of one with a gait belt. 3. Identified all residents that ambulate with staff assistance may be at risk for the same deficient practice. 4. Educated the NA involved in the incident regarding following plan of care for ambulation status. Education provided to all NA and nurses regarding following plan of care for residents. 5. Ensured all residents had the correct ambulation status on care plan and nursing assistant care sheets. 6. Education of all staff regarding abuse and neglect, reporting policy, expectations including timeframe. 7. Monitoring will be done via audits of direct audit of staff during resident ambulation five times per week x 4 weeks, three times per week x 4 weeks, one time per week for 4 weeks x 4 weeks. Audits will be brought to quality assurance performance improvement (QAPI) to determine ongoing audits. 8. Director of Nursing of designee will be responsible for the compliance of the action plan.	F 689		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 725		6/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 725	Continued From page 6 resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide sufficient staffing to ensure residents received the care and assistance they needed in a timely manner for 4 of 5 residents (R5, R1, R3, & R6) reviewed for call lights. This caused actual harm to R5 when she waited nearly three hours for her call light to be answered causing her to experience increased anxiety, distress, fear, and feelings of worthlessness and helplessness. Findings include: R5 R5's Minimum Data Set (MDS) assessment	F 725	Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	

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F 725	Continued From page 7 dated 3/30/25, indicated she had intact cognition and no behaviors or rejections of care. R5 had diagnoses including multiple sclerosis (chronic disease affecting the central nervous system), anxiety disorder, major depressive disorder, and morbid obesity. R5 was frequently incontinent of bowel and bladder and required substantial staff assistance with toileting hygiene, bathing, dressing, and mobility in bed. R5 was dependent on staff for transfers and used a motorized wheelchair independently. R5's urinary incontinence care plan interventions dated 2/11/25, included keep call light within reach, provide incontinence care after each incontinent episode, toilet per request, and staff to toilet every two hours and as needed with extensive assistance. R5's activities of daily living (ADL) care plan included intervention dated 2/11/25, to discuss with staff how to honor R5's preferences and provide care in a timely manner. R5's psychosocial well-being care plan dated 1/15/25, identified potential for trauma related to history of sexual abuse, physical abuse, and mental abuse. Interventions dated 1/15/25 included observe for signs of adjustment difficulties such as inability to pursue interests or activities or sad or anxious mood. R5's mood state care plan dated 5/26/22 identified R5 was at increased risk for mood issues related to anxiety disorder, suicidal ideations in the setting of delirium, toxic encephalopathy, new an unfamiliar environment, and legal blindness. Intervention dated 5/16/24, noted psychology was to evaluate and treat as needed. R5's psychology provider note by licensed independent clinical social worker (LICSW)-A dated 1/31/25, indicated R5 had diagnoses	F 725	F725 Sufficient Nursing Staff R5, R3, R6 were interviewed, and all agreed that their call lights are being answered in a timely manner. R1 was discharged from the facility on 6.2.2025. All residents have the potential to be affected. Resident call lights are being monitored to be answered in a timely manner. All staff have been educated on the expectation of assisting with call lights and the procedure for monitoring active call lights. The facility completed a root cause analysis for the incident and determined that staff were not utilizing their walkie talkies and not monitoring the call light display boards, which is how the staff are alerted of any active call lights. The weekend nurse on-call or designee will be calling the facility at the time of shift change to ensure appropriate staffing levels. Call light escalation email notifications are being sent to the DON and Administrator at 25 minutes for monitoring. Education on call light expectations and the procedure for monitoring active call lights will be completed with new hires at the time of orientation and completed with new agency staff that work at the time of their first scheduled shift. Call light audits will be completed on ten residents per week, on rotating shifts for four weeks. Then six residents per week	

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F 725	Continued From page 8 including major depressive disorder and anxiety disorder. R5's mental status exam noted dysthymic (mild long-lasting depressed) mood, ruminating (persistent negative) thoughts, tearful affect, and tearful behavior. R5 reported an incident of waiting for her brief to be changed after a bowel movement (BM), "which she believes contributed to current UTI [urinary tract infection]." Treatment recommendations included "it remains of benefit for [R5] to have brief changes after BM's as soon as possible, to reduce risk of developing UTI's which she seems to be prone to. This would aid in decreasing anxiety levels." R5's psychology provider note by LICSW-A dated 2/21/25, indicated R5 presented with anxious and depressed mood of sadness, overwhelmed, grief, stress, difficulty concentrating, and fatigue. R5 reported she had another UTI and endorsed anxiety around this. R5's Long Term Care Social Service assessment dated 3/26/25, indicated she had mood appropriate to circumstance and mood was affected by diagnoses. She did not have mood symptoms of depression, crying, or withdrawal from activities and her mood was not restless, anxious, or inclusive of complaints. R5 was identified as expressing her feelings openly and coping well. She did not distort or misrepresent events, worry/deny/cry, or display ineffective coping skills such as distancing self, anger, or withdrawal from life at facility. The facility's Grievances Log included a grievance entry dated 4/26/25 voiced by R5. The concern section noted R5 reported on Saturday 4/26/25 around 3:00 p.m. she put on her call light	F 725	for four weeks, followed by four residents per week for four weeks. In the facilities performance improvement plan for call lights, a call light response goal was self-identified for 30 minutes for one month, and the call light response goal will be reduced each month until it reaches 15 minutes. Resident interviews regarding needs being met and timely response to call lights will be completed on 5 residents per week for four weeks, followed by 3 residents per week for four weeks, followed by 1 resident per week for four weeks. Audit results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Date of compliance: 6.17.2025	

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F 725	Continued From page 9 for assistance transferring from chair to commode and waited an hour for a nurse to come in. The nurse said she was going to turn the call light off and then back on and let a nursing assistant (NA) know she was waiting. R5 requested the call light not be turned off as she hadn't been assisted yet. Nurse left call light on and informed a NA who then assisted. The findings section of the log noted "The resident's call light was not answered for approximately one hour after activation on Saturday, 4/26, around 3:00 PM. When a nurse eventually responded, she did not provide direct assistance but informed an aide, who later assisted the resident. The nurse initially planned to reset the call light before notifying staff, but the resident requested it remain on until assistance was received." The action section noted "Staff were reminded of the importance of promptly responding to call lights to ensure residents receive timely assistance. Nursing staff were specifically instructed not to reset a call light until the resident's needs have been fully addressed. The situation was reviewed with the care team to reinforce effective communication practices and appropriate procedures for escalating any delays in care. The resident was informed of the concern and the steps being taken to address it." R5's Device Activity Report (call light log) dated 4/12/25 through 5/14/25, included but was not limited to the following reset times (time from when light is activated to when it is cleared): - 4/12/25 at 7:27 p.m., 20 minutes and 46 seconds - 4/12/25 at 10:40 p.m., 25 minutes and 48 seconds - 4/13/25 at 7:57 a.m., 100 minutes and 22 seconds	F 725		

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F 725	Continued From page 10 - 4/15/25 at 2:09 p.m., 21 minutes and 35 seconds - 4/16/25 at 5:05 p.m., 29 minutes and 19 seconds - 4/17/25 at 3:37 p.m., 24 minutes and 32 seconds - 4/19/25 at 7:57 a.m., 23 minutes and 7 seconds - 4/20/25 at 8:50 a.m., 43 minutes and 48 seconds - 4/20/25 at 12:58 p.m., 61 minutes and 51 seconds - 4/20/25 at 9:45 p.m., 22 minutes and 36 seconds - 4/22/25 at 7:38 a.m., 34 minutes and 54 seconds - 4/22/25 at 1:18 p.m., 49 minutes and 30 seconds - 4/22/25 at 9:54 p.m., 28 minutes and 3 seconds - 4/25/25 at 1:16 p.m., 26 minutes and 8 seconds - 4/26/25 at 7:13 a.m., 202 minutes and 18 seconds - 4/26/25 at 3:38 p.m., 64 minutes and 31 seconds - 4/26/25 at 5:50 p.m., 20 minutes and 30 seconds - 4/27/25 at 5:40 p.m., 30 minutes and 14 seconds - 4/28/25 at 6:01 p.m., 32 minutes and 32 seconds - 5/3/25 at 1:03 p.m., 22 minutes and 52 seconds - 5/6/25 at 7:41 a.m., 57 minutes and 32 seconds - 5/6/25 at 1:00 p.m., 43 minutes and 42 seconds - 5/6/25 at 5:20 p.m., 26 minutes and 2 seconds - 5/7/25 at 7:34 a.m., 24 minutes and 35 seconds - 5/7/25 at 5:57 p.m., 31 minutes and 49 seconds - 5/10/25 at 12:12 p.m., 174 minutes and 8 seconds - 5/11/25 at 12:58 a.m., 20 minutes and 55 seconds	F 725		

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F 725	Continued From page 11 - 5/11/25 at 2:12 p.m., 59 minutes and 19 seconds - 5/11/25 at 7:17 p.m., 26 minutes and 51 seconds - 5/12/25 at 3:16 p.m., 31 minutes and 41 seconds - 5/13/25 at 3:24 p.m., 18 minutes and 14 seconds - 5/13/25 at 5:52 p.m., 29 minutes and 34 seconds During an interview on 5/14/25 at 2:19 p.m., R5 stated "there are huge issues with call lights." R5 stated at night sometimes nobody would answer her call light so she would have to use a telephone to call the nursing station on her unit and another unit to request assistance. R5 explained on a good day call lights are answered in 15 minutes, on a bad day anytime between half an hour and 45 minutes, and on a real bad day a lot longer. R5 noted there were occasions she had to wait "marathon times" with the most recent incident on Saturday 5/10/25. R5 stated a nursing assistant (NA) got her up and dressed in the morning and told her the NA assigned to her had left sick an hour into the day shift. The NA who had helped her was then pulled and put on a medication cart to work as a medication aide because they were short a nurse, leaving one NA working the whole floor. R5 stated around 12:15 p.m. she turned her call light on because she needed to have her brief changed. She was sitting in her recliner, it was nice out, and she wanted to go outside. She turned on the light to have her brief changed and transfer to her electric wheelchair to go outside. R5 stated, "no one came until 3:15 in the afternoon, nobody came, not one person to check on me." Review of R5's call light log identified her call light was	F 725		

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F 725	Continued From page 12 activated on 5/10/25 at 12:12 p.m. and was not reset for 2 hours 54 minutes and 8 seconds. R5 stated the evening shift NA stopped in her room while orienting another NA who was agency staff and they were not aware her light was on when they came by, but R5 told them what she needed. R5 stated she was a "mell of a hess [sic]" by this point, "I was angry at being ignored, I was terrified that here I am again, and grateful I wasn't in serious physical danger." R5 noted this could have been fatal to somebody so yeah, I'm grateful for that, but I'm afraid, it makes me afraid about being here. I'm never safe here. After she was assisted to the commode she had NAs put her in bed. R5 was afraid by that time, she didn't know who was going to be working that night. She didn't feel comfortable enough to be in her wheelchair and go outside. "I thought just put me in my bed so I can be as safe as possible." R5 noted the facility had been staggering nurses and instead of two nurses starting at 3:00 p.m. they had one start at 3:00 p.m. and one start at 5:00 p.m. which made R5 not feel secure and safe. R5 stated "I don't think emotionally I have recovered" R5 did not feel safe in the late afternoon or early morning because staff don't help. R5 explained another recent instance where she waited an extended time for assistance. R5 had a large BM and had BM all over herself. She informed an NA that she needed assistance because "I know I needed to be changed, and I needed to be changed fast because I didn't want to have another UTI." R5 indicated the NA told her he needed to finish passing out lunch trays and collecting them and would then get to her. R5 then went to the nursing station and informed staff she needed to be changed now, went back to her room, and turned on her call light. After 15 to 20 minutes, she left her room in her wheelchair	F 725		

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F 725	Continued From page 13 to find the NA, told him she needed to be changed now, he stated he had to do something else first, and she returned to her room. After waiting another 15 to 20 minutes she went looking for him again, and he again said he had to go do something in another room. After 15 to 20 more minutes, she found him again and he did it again a third time. R5 stated she "lost it" and went back to my room and she "wept and wailed". After about five minutes, the NA arrived and asked why she was crying and she said because "you won't change me." The NA got a second NA and the two then assisted with cleaning her up. R5 stated she was very upset by this incident. During an interview on 5/15/25 at 12:05 p.m., trained medication aide (TMA)-A stated aides answer call lights and "other staff don't answer call lights, but they should." TMA-A noted it was hard to answer call lights with three aides and sometimes two working. TMA-A stated ten minutes was too long to take to answer a call light and if somebody needs to go to the bathroom they can't wait, "we don't have enough staff to do that." TMA-A stated "with two aides it is a struggle. If we had more staff it would be helpful with call lights. TMA-A noted R5 used the call light when she needed to use the commode or wanted to come out of her room and staff did not have time because two people were needed to transfer R5. TMA-A stated, R5 did get upset about the call light after waiting, "her face changes, she is mad". During an interview on 5/15/25 at 12:26 p.m., registered nurse (RN)-C stated there were not enough staff to do what needed to be done for the residents and "answer call lights like we should." RN-C stated she thought the recent	F 725		

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F 725	Continued From page 14 instance when R5 had to wait approximately three hours for her call light to be answered was sad and "it's obvious how you would feel, neglected, afraid." RN-C explained there should be three aides at all times and noted call lights were more of a problem when there were less than three NA's working on the unit. During an interview on 5/15/25 at 9:50 a.m., staffing coordinator (SC) reviewed the schedule from Saturday 5/10/25 for R5's unit. She noted the day shift had two nurses, an RN from 6:30 a.m. to 1:00 p.m. and an LPN from 6:30 a.m. to 3:00 p.m. The day shift had three NA's working, with two scheduled from 6:30 a.m. to 2:45 p.m. and one scheduled from 6:30 a.m. to 3:00 p.m. The NA scheduled to work until 3:00 p.m. came in for about an hour in the morning, became sick and left, and another NA came in to replace her. The evening shift had two nurses and two NA's. One LPN was scheduled from 3:00 p.m. to 8:00 p.m. and the second LPN scheduled from 4:00 to 11:00 p.m. called out and was replaced by an RN pulled from a different unit. Three NA's were scheduled to work: one from 2:30 p.m. to 11:00 p.m., one from 3:00 p.m. to 11:00 p.m., and one from 3:00 p.m. to 9:00 p.m. Two NA's worked the evening shift as the third was pulled to a different unit to work as a TMA. The SC stated one of the aides from another unit was "probably floating" between their assigned unit and R5's unit. During an interview on 5/15/25 at 4:33 p.m., the nurse manager for R5's unit, RN-D, stated she didn't know what was going on with call lights, "we need to work on getting those lights." Call lights should be answered in no more than five minutes. If a light was not answered timely a resident would may not feel good about it or disappointed,	F 725		

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F 725	Continued From page 15 RN-D noted she "wouldn't be happy." RN-D recalled the instance on 4/26/25 when R5 had to wait an hour for her call light to be answered and thought it was because an aide had been sick and left early. RN-D stated she talked to R5 about this and she was "not happy." Whoever saw the light should have answered right away and it was unacceptable. RN-D had also spoken with R5 about the instance on 5/10/25 when she waited approximately three hours for her call light to be answered and R5 "wasn't happy." Long call lights had a negative effect on residents when they had to wait that long for assistance and it was definitely something we need to work on with the call lights, whether it is a weekend or not. Regarding how long call light times affected R5, RN-D stated she knew for sure R5 did get anxious and worried because R5 had told as much. RN-D stated she had not looked into how call light logs compared to staffing and hadn't heard from her staff that they were related. During an interview on 5/15/25 at 4:00 p.m., the director of social services (DSS) stated long call light wait times "are negative towards people's psychosocial well-being" and could make residents not trust our staff, could impact how people feel about being safe here. The DSS noted some residents could get a lot more anxious if their call lights were not being answered, especially if they already have anxiety. An increase in anxiety would be considered a negative impact to psychosocial well-being. The DSS reviewed her concerns (grievances) database and noted a concern from R5 on 5/10/25 that her call light was on for three hours and noted staff were still looking into this with nurse manager RN-D assigned to investigate. She identified an additional concern from R5	F 725		

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F 725	Continued From page 16 dated 4/26/25 when she waited for over an hour for her light to be answered which was confirmed when staff reviewed call light logs. The DSS assumed this impacted R5 negatively, could be harmful, and probably increased her anxiety levels. The DSS noted waiting one or three hours for a call light to be answered could impact a resident's sense of dignity or self-worth. She expected call lights to be answered "no later than 20 minutes" and long call light wait times "wouldn't feel good." During a return phone call interview on 5/19/25 at 4:45 p.m., licensed independent clinical social worker (LICSW)-A stated she had been seeing R5 since she admitted to the facility and saw R5 for her depression, chronic adjustment distress, anxiety, and post-traumatic stress symptoms. LICSW-A was aware of R5's long call light times, including the one that took staff three hours to answer. LICSW-A noted in response to the long call light times it made R5 feel helpless, a lack of control, and like her needs don't matter." R5 was reliant on staff to use the bathroom or get transferred. Long call light wait times "certainly impacts her [R5's] anxiety levels." R5's reported three-hour wait time was "a long wait time, I would expect that most people would feel pretty distressed by that. LICSW-A felt R5's distress level and response is completely understandable and appropriate to the situation. LICSW-A also noted R5 had brought up call light wait times with her previously. LICSW-A believed it did impact R5's mood and feeling of lack of being in control of her situation. Additionally, feeling of helplessness that R5 requested help and not only has it not arrived, but then she has had to wait for that long amount of time. LICSW-A stated for R5 "it kind of filters into her thought of "do my needs	F 725		

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F 725	Continued From page 17	F 725		

matter?'" and when her call light was not answered timely "she feels depressed." R5 "was angry and tearful" when talking about this experience. LICSW-A stated for her to wait that long, that is harmful to her. R5 had filed multiple complaints and grievances and spoken with facility staff and the ombudsman, but there has not been any improvement so she worries. LICSW-A noted R5 had expressed fears about what could happen to her in the time frame while she was waiting for a call light to be answered, and the worry had been "kind of steady." LICSW-A noted adjusting to the facility "has been very difficult for her [R5]" and long call light wait times "doesn't help." LICSW-A noted R5 had been better adjusted over the last year and a half but then if a circumstance like this comes up it brings her back to some of those feelings.

R1
R1's MDS assessment dated 2/2/25, indicated she had intact cognition and no behaviors or rejections of care. R1 had diagnoses including Parkinson's disease, acute pain due to trauma, back pain, and abnormalities of gait and mobility. She was occasionally incontinent of urine, and required substantial staff assistance with toileting, bathing, bed mobility, and transfers.

R1's mobility care plan dated 3/1/25, identified she needed staff assistance with bed mobility, transfers, ambulation, and locomotion due to immobility. Intervention dated 5/12/25, directed staff to ensure the call light was in reach and encourage R1 to use it to make needs known. R1's urinary care plan with interventions dated 2/11/25, directed staff to keep call light in reach, toilet every two to three hours and as needed, and toilet per request. Her communication care

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	245255	A. BUILDING _____ B. WING _____	C 05/15/2025

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 725	Continued From page 18 plan dated 2/11/25, identified R1 preferred to have her call light on the table in her room and would also like to have a bell to ring if she needed assistance. Intervention dated 2/11/25, directed to discuss with staff how to honor preferences and provide care in a timely manner. R1's call light log dated 4/12/25 through 5/14/25, included but was not limited to the following reset times: - 4/12/25 at 11:05 a.m., 28 minutes and 46 seconds - 4/12/25 at 5:32 p.m., 33 minutes and 39 seconds - 4/12/25 at 8:24 p.m., 26 minutes and 58 seconds - 4/13/25 at 8:27 a.m., 25 minutes and 25 seconds - 4/13/25 at 9:17 a.m., 32 minutes and 59 seconds - 4/13/25 at 12:37 p.m., 34 minutes and 42 seconds - 4/15/25 at 12:21 p.m., 21 minutes and 39 seconds - 4/16/25 at 10:57 a.m., 18 minutes and 41 seconds - 4/16/25 at 12:20 p.m., 31 minutes and 20 seconds - 4/16/25 at 5:20 p.m., 24 minutes and 22 seconds - 4/16/25 at 7:32 p.m., 32 minutes and 38 seconds - 4/19/25 at 1:38 a.m., 26 minutes and 51 seconds - 4/20/25 at 11:12 a.m., 29 minutes and 16 seconds - 4/20/25 at 3:56 p.m., 23 minutes and 32 seconds - 4/20/25 at 7:41 p.m., 36 minutes and 34	F 725		

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F 725	Continued From page 19 seconds - 4/21/25 at 10:01 a.m., 36 minutes and 51 seconds - 4/22/25 at 12:28 p.m., 24 minutes and 18 seconds - 4/24/25 at 9:13 a.m., 265 minutes and 5 seconds - 4/24/25 at 1:40 p.m., 29 minutes and 14 seconds - 4/20/25 at 10:38 a.m., 22 minutes and 34 seconds - 5/3/25 at 10:52 a.m., 46 minutes and 44 seconds - 5/4/25 at 1:54 p.m., 53 minutes and 24 seconds - 5/5/25 at 6:09 p.m., 19 minutes and 12 seconds - 5/6/25 at 11:47 a.m., 24 minutes and 4 seconds - 5/6/25 at 5:39 p.m., 31 minutes and 19 seconds - 5/7/25 at 9:56 a.m., 22 minutes at 24 seconds - 5/7/25 at 5:56 p.m., 26 minutes and 44 seconds - 5/7/25 at 9:46 p.m., 49 minutes and 43 seconds - 5/10/25 at 8:06 a.m., 67 minutes and 58 seconds - 5/10/25 at 9:40 a.m., 21 minutes and 56 seconds - 5/10/25 at 5:27 p.m., 31 minutes and 21 seconds - 5/10/25 at 6:03 p.m., 21 minutes and 49 seconds - 5/11/25 at 10:22 a.m., 24 minutes and 52 seconds - 5/11/25 at 1:32 p.m., 30 minutes and 56 seconds - 5/12/25 at 7:56 p.m., 27 minutes and 33 seconds During an interview on 5/12/25 at 3:08 p.m., R1 stated things aren't going well. Staff would not answer the light. R1 had a bell that one of the nurses gave him and directed R1 that if staff did	F 725		

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F 725	Continued From page 20 not answer the call light in a reasonable time, to use the bell. R1 stated "I do scream" and staff would tell R1 to quit it. Staff would not answer the bell either, so R1 gave it away. R1 stated she would press her call light and wait so long that she turned it off because staff didn't answer. R1 stated she had fallen recently while trying to organize laundry in her room and staff told her to use her call light for assistance, but that was "a joke" because staff don't answer her light and have said they are shorthanded. R1 stated she used her call light when she needed to use the bathroom but staff don't answer, so "I end up going in my pull-ups" because she couldn't hold it for that long. R1 stated she felt helpless, and it sometimes took one or two hours for her call light to be answered. She stated, "I am bitter because I had to mess myself" because she could not get staff to come help her. On 5/12/25 at 5:18 p.m., a call light digital alarm board in the hallway displayed displayed "alarm [R1's room number] 15 minutes" and was flashing. NA-C entered R1's room. R1's call light log indicated her light was activated on 5/12/25 at 5:00 p.m. and was not cleared for 17 minutes and 58 seconds. Upon exiting, NA-C stated R1 wanted to go to the bathroom and usually if her call light is on it is because she wanted water or to go to the bathroom. NA-C stated she had taken R1 to the bathroom and cleaned her up after toileting. During an interview on 5/13/25 at 9:23 a.m., R1's friend and power of attorney (POA)-A stated R1 had called her crying before, stating she's uncomfortable, needed to get up, needed to go to the bathroom, and needed pain medication. POA-A told R1 to ring her bell while still on the	F 725		

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F 725	Continued From page 21 phone to see if staff come in and "she's ringing the bell, and nothing happens." POA-A stated this was not okay. R3 R3's MDS assessment dated 3/3/25, indicated she had intact cognition and no behaviors or rejections of care. R3 had diagnoses including stage four pressure ulcer of the sacral region (wound with full thickness tissue loss and exposed bone, tendon, or muscle over the tailbone area), low back pain, heart failure, non-Alzheimer's dementia, and depression. She was occasionally incontinent of bowel and bladder and required supervisory staff assistance with toileting hygiene and bathing, and partial assistance with footwear and walking. R3's urinary care plan included interventions dated 2/13/25, including keep call light within reach, staff to toilet every two to three hours and as needed with assist of one staff, and toilet per request. R3's routines care plan included intervention dated 2/13/25, directing "discuss with staff how to honor my preferences and provide care in a timely manner." R3's activities of daily living care plan included interventions dated 8/9/24, "I can verbally ask for assistance, I need assistance to help me remain free from skin breakdown and respect my dignity." Her pain care plan included a goal dated 5/3/25, to be comfortable. Intervention dated 9/5/24, noted interventions for pain included prescribed medications, relaxation, and distraction. R3's call light log dated 4/12/25 through 5/14/25, included the following reset times: - 4/12/25 at 5:20 p.m., 40 minutes and 21 seconds	F 725		

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F 725	Continued From page 22 - 4/20/25 at 12:21 p.m., 26 minutes and 36 seconds - 4/21/25 at 12:11 p.m., 49 minutes and 11 seconds - 4/21/25 at 3:45 p.m., 36 minutes and 22 seconds - 4/26/25 at 8:53 a.m., 106 minutes and 54 seconds - 4/28/25 at 7:04 p.m., 44 minutes and 12 seconds - 4/30/25 at 8:41 a.m., 17 minutes and 2 seconds - 5/1/25 at 8:46 a.m., 51 minutes and 35 seconds - 5/4/25 at 12:21 p.m., 17 minutes and 43 seconds - 5/5/25 at 9:10 a.m., 124 minutes and 52 seconds - 5/5/25 at 12:52 p.m., 45 minutes and 40 seconds - 5/5/25 at 2:54 p.m., 33 minutes and 14 seconds - 5/7/25 at 7:36 a.m., 114 minutes and 47 seconds - 5/7/25 at 12:56 p.m., 32 minutes and 41 seconds - 5/8/25 at 1:15 p.m., 56 minutes and 11 seconds - 5/10/25 at 9:47 a.m., 105 minutes and 27 seconds - 5/10/25 at 6:34 p.m., 75 minutes at 14 seconds - 5/11/24 at 9:02 a.m., 119 minutes and 15 seconds - 5/13/25 at 11:01 a.m., 24 minutes 35 seconds - 5/14/25 at 8:38 p.m., 38 minutes and 14 seconds On 5/13/25 at 11:04 a.m., NA-A stated staffing was short sometimes, and they could use a little help. NA-A noted call lights should be answered in either eight to 10 minutes or five to eight minutes, she couldn't remember. NA-A noted she would usually turn call lights off right away and	F 725		

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F 725	Continued From page 23 then go look for someone to help her if she was unable to provide the needed assistance. She stated answering call lights can be a challenge and lights were usually on "for thirty minutes plus" which was pretty bad and a long time. NA-A noted she wouldn't like this if it was her family member. At 11:24 a.m., a call light digital alarm board in the hallway displayed "alarm [R3's room number] 20 minutes" and was flashing. NA-A entered R3's room and stated she was there because R3's call light was on and confirmed it had been on for 20 minutes. During an interview on 5/13/25 at 11:24 a.m., R3 stated it had "been a while" since she pressed her call light. R3 asked NA-A for as needed pain medication for back pain rated six out of 10. R3 thought nursing staff all went on break every hour because it sometimes took a long time for call lights to be answered. R3 noted call light wait times were not timely around mealtimes, as staff were busy preparing and serving meals and passing trays. R3 stated she realized staff were busy and she just had to be patient, but sometimes staff got mad and "then they ignore you." R6 R6's MDS assessment dated 2/18/25, indicated she had intact cognition and no behaviors or rejections of care. R6 had diagnoses including encephalopathy (disturbance in brain's function), sclerosis, anxiety, depression, and functional quadriplegia (complete inability to move all four limbs due to extreme debility or frailty). She was frequently incontinent of bowel and had an indwelling urinary catheter. R2 was dependent on staff for assistance with all cares, activities of daily living, and mobility.	F 725		

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F 725	Continued From page 24 R6's mobility care plan dated 2/13/25, identified she needed assistance due to functional quadriplegia. Intervention dated 5/7/26, directed "staff to ensure call light is in resident's reach while in room and encourage to use it to make needs known." R6's communication care plan dated 4/24/25, noted she used a specialized call light she accessed with her face/chin. R6's urinary care plan included interventions dated 2/13/25, including keep call light within reach, staff to toilet every two to three hours and as needed, and toilet per request. R6's call light log dated 4/12/25 through 5/14/25, included the following reset times: - 4/13/25 at 8:56 a.m., 58 minutes and 55 seconds - 4/18/25 at 2:38 p.m., 18 minutes and 4 seconds - 4/20/25 at 5:10 a.m., 28 minutes and 8 seconds - 4/20/25 at 7:04 a.m., 37 minutes and 0 seconds - 4/20/25 at 9:26 a.m., 30 minutes and 55 seconds - 4/20/25 at 11:00 a.m., 55 minutes and 37 seconds - 4/20/25 at 12:56 p.m., 51 minutes and 14 seconds - 4/21/25 at 9:20 a.m., 22 minutes and 45 seconds - 4/21/25 at 10:10 a.m., 43 minutes and 0 seconds - 4/21/25 at 1:31 p.m., 25 minutes and 3 seconds - 4/21/25 at 7:13 p.m., 23 minutes and 59 seconds - 4/22/25 at 5:22 a.m., 20 minutes and 4 seconds - 4/22/25 at 7:39 a.m., 30 minutes and 28 seconds - 4/22/25 at 9:16 a.m., 36 minutes and 43 seconds	F 725		

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F 725	Continued From page 25 - 4/22/25 at 10:02 a.m., 20 minutes and 31 seconds - 4/24/25 at 11:22 a.m., 20 minutes and 36 seconds - 4/24/25 at 5:01 p.m., 18 minutes and 47 seconds - 4/25/25 at 2:08 p.m., 19 minutes and 55 seconds - 4/25/25 at 2:35 p.m., 18 minutes and 50 seconds - 4/26/25 at 5:11 a.m., 60 minutes and 40 seconds - 4/26/25 at 6:41 a.m., 96 minutes and 29 seconds - 4/26/25 at 9:32 a.m., 55 minutes and 11 seconds - 4/26/25 at 10:54 a.m., 61 minutes and 9 seconds - 4/26/25 at 12:21 p.m., 34 minutes and 50 seconds - 4/26/25 at 2:26 p.m., 18 minutes and 4 seconds - 4/26/25 at 3:27 p.m., 31 minutes and 45 seconds - 4/27/25 at 2:34 p.m., 18 minutes and 50 seconds - 4/27/25 at 3:36 p.m., 36 minutes and 5 seconds - 4/27/25 at 5:30 p.m., 22 minutes and 24 seconds - 4/27/25 at 10:07 p.m., 50 minutes and 2 seconds - 4/28.25 at 5:25 a.m., 19 minutes and 3 seconds - 4/28/25 at 10:46 a.m., 48 minutes and 21 seconds - 4/29/25 at 7:50 a.m., 21 minutes and 13 seconds - 4/30/25 at 2:24 p.m., 23 minutes and 32 seconds - 5/1/25 at 10:56 a.m., 18 minutes and 32 seconds	F 725		

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F 725	Continued From page 26 - 5/2/25 at 6:30 a.m., 28 minutes and 24 seconds - 5/2/25 at 7:09 a.m., 51 minutes and 11 seconds - 5/2/25 at 11:41 a.m., 36 minutes and 59 seconds - 5/4/25 at 5:40 a.m., 37 minutes and 11 seconds - 5/4/25 at 12:08 p.m., 29 minutes and 32 seconds - 5/4/25 at 1:49 p.m., 27 minutes and 39 seconds - 5/4/25 at 1:18 p.m., 21 minutes and 34 seconds - 5/5/25 at 5:28 a.m., 29 minutes and 18 seconds - 5/5/25 at 8:37 a.m., 28 minutes and 18 seconds - 5/5/25 at 10:43 a.m., 20 minutes and 1 second - 5/5/25 at 1:49 p.m., 22 minutes and 15 seconds - 5/5/25 at 2:38 p.m., 54 minutes and 56 seconds - 5/5/25 at 6:58 p.m., 71 minutes and 0 seconds - 5/6/25 at 12:04 p.m., 26 minutes and 50 seconds - 5/7/25 at 4:17 p.m., 25 minutes and 59 seconds - 5/10/25 at 7:28 a.m., 45 minutes and 41 seconds - 5/10/25 at 9:53 a.m., 63 minutes and 46 seconds - 5/10/25 at 12:58 p.m., 106 minutes and 44 seconds - 5/10/25 at 2:46 p.m., 81 minutes and 29 seconds - 5/10/25 at 5:43 p.m., 72 minutes and 11 seconds - 5/10/25 at 7:26 p.m., 29 minutes and 53 seconds - 5/10/25 at 10:18 p.m., 32 minutes and 12 seconds - 5/11/25 at 3:47 a.m., 27 minutes and 26 seconds - 5/11/25 at 9:19 a.m., 92 minutes and 53 seconds - 5/11/25 at 7:13 p.m., 19 minutes and 51 seconds - 5/11/25 at 7:40 p.m., 20 minutes and 37	F 725		

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F 725	Continued From page 27 seconds - 5/11/25 at 10:00 p.m., 43 minutes and 56 seconds - 5/12/25 at 12:13 p.m., 36 minutes and 55 seconds - 5/12/25 at 3:23 p.m., 26 minutes and 10 seconds - 5/13/25 at 7:33 a.m., 44 minutes and 6 seconds - 5/14/25 at 9:32 a.m., 37 minutes and 47 seconds During an interview on 5/14/25 at 3:05 p.m., R6 stated she used her chin to press her specialized call light. R6 stated that when she used her call light staff sometimes came right away and sometimes "who knows" when they would come. R6 stated it pissed her off when staff didn't answer her call light in a timely manner and it "doesn't feel very good." She noted some staff would turn her call light off and leave without helping and she sometimes had to wait a really long time for assistance. R6 noted she had limited mobility and that's why she used the call light for staff assistance, such as when she wanted a sip of water. During an interview on 5/14/25 at 12:25 p.m., licensed practical nurse (LPN)-B stated everyone was responsible for answering call lights and they should be answered as soon as possible. LPN-B stated anything over 10 minutes was too long. When lights were not answered in a timely manner, LPN-B thought residents would feel ignored and might feel neglected. If it were her family member, she would feel "pretty upset." During an interview on 5/13/25 at 2:50 p.m., RN-B stated call lights are answered by everyone and if you can't provide the assistance needed,	F 725		

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F 725	Continued From page 28 you should leave the call light on and get somebody who can help. RN-B stated she didn't know how quickly call lights should be answered, but maybe within half an hour. RN-B noted if staff were doing cares with another resident it would be "a little longer." RN-B stated staffing could be better and management had been having nurses leave early and come in late. She stated this didn't impact care as long as staff weren't busy but if multiple residents needed the nurse at the same time they didn't have the staff to get to them all quickly enough. RN-B thought more NA's were needed; when there were only two NA's or two with an extra floating between multiple units instead of three NA's, it was hard to answer call lights from 30-something residents. RN-B did not identify specific resident concerns with excessive call light response wait times. During an interview on 5/14/25 at 11:49 a.m., RN-C stated management sometimes had nurses leave early which made it "difficult" to get their work done. She recalled a recent instance where they were short one NA on the shift. RN-C stated call lights should be answered immediately and answering them after 15 minutes or half an hour was not okay. She stated call lights can be "tricky" and sometimes call lights would be on for a while when they should have been answered already. RN-C stated call lights were mostly answered on time and did not indicate awareness of resident concerns regarding excessive call light response wait times. During an interview on 5/14/25 at 5:22 p.m., the administrator stated nurse managers had been conducting call light audits. The administrator stated she hadn't heard of any concerns identified on the audits but had reviewed the call light logs	F 725		

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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 725	Continued From page 29 requested by surveyors and they did not align with what was identified in the audits. During an interview on 5/15/25 at 3:39 p.m., the administrator stated call light times had not been identified as a continued issue through the audits, but they should have been. She noted call lights should be answered in less than 15 minutes and 15 minutes was too long. She confirmed a three-hour wait was too long, would make a resident feel "not good," and the mental and emotional impact of this would be not positive. During an interview on 5/15/25 at 8:15 a.m., the director of nursing (DON) stated everyone was responsible for answering call lights and they should be answered as soon as possible and identified her expectation as answering lights within 15 minutes, although sometimes that wasn't realistic. She noted call lights not being answered timely impacted residents because they had to wait longer for their needs to be met and this probably made them feel "not good." If a resident soiled themselves while waiting for a light to be answered they would feel "frustrated, worried, scared." If it took three hours for a light to be answered, the DON stated a resident wouldn't feel safe and noted call lights can be emergencies. The DON reviewed the call light audits completed by nurse managers and stated the call light times were not in line with her expectations and the data included in the audits identified ongoing concerns. Review of the facility Quality Assurance process identified past non compliancy with F725 citation for sufficient nursing staff related to call light times identified in a state agency survey with plan of correction dated 1/15/25. Facility Quality	F 725		

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F 725	Continued From page 30 Council meeting PowerPoints and corresponding minute meeting notes for months of March and April 2025 indicated related audits were being completed. The Quality Council documentation identified data collection of resident concerns (grievances) and call light log audits. Documentation failed to include details of the audits completed or specifics of identified resident concerns. The Quality Assurance process documentation failed to identify, investigate, analyze, or respond to ongoing current concerns with excessively long call light response wait times. Facility policy titled Call Lights - Call System Activation and Response dated 5/28/24, identified "The purpose of this procedure is to ensure timely responses to resident requests and needs. Residents are provided with a means to call for staff assistance through a communication system that directly notifies a staff member or a centralized work station." The policy included, "Each resident is provided with a means to call staff directly for assistance ... Calls for assistance may be triaged and answered as soon as possible based on immediate needs ... Call light response times are reviewed as part of the QAPI program." Facility policy titled Resident Rights and Notification of Resident Rights dated 1/16/24, included "The facility acts to protect and ensure the rights of residents." The policy noted resident right included responsive service, appropriate health care, respect and dignity, and accommodation of needs. The Facility Assessment dated 8/26/24, included a list of person-centered service and care offered	F 725		

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F 725	Continued From page 31 based upon the needs of those the facility served. This list for bowel/bladder included "responding to requests for assistance to the bathroom/toilet promptly to maintain continence and promote resident dignity." The list for mental health and behavior included "identify and implement interventions to help support individuals with issues such as dealing with anxiety." The list for person-centered/directed care included "find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process ... Support emotional and mental well-being." The Facility Assessment Follow Up section included areas identified by the facility assessment and action to be taken/already taken this year. Areas included staffing with action of agency reduction as well as QAPI initiatives/performance improvement projects with action of call light response time.	F 725		
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(f). 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, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		6/17/25

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F 755	Continued From page 32 §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 medications were administered in accordance with physician orders and failed to identify and report medication errors for 2 of 3 (R1, R2) residents reviewed for medication administration. Findings include: R1 R1's Minimum Data Set (MDS) assessment dated 2/2/25, indicated she admitted to the facility on 10/29/24 with diagnoses including acute pain due to trauma and dorsalgia (pain in the upper back). R1 was on a scheduled pain medication regimen and received as needed (PRN) pain medications. R1's care plan revised 2/6/25, identified R1 experienced pain and discomfort. Interventions included administration of scheduled and PRN	F 755	Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F755 Pharmacy Srvcs/Procedures/Pharmacist/Records R1 was discharged from the facility on 6.2.2025. R2□s albuterol is being administered per physician orders.	

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F 755	Continued From page 33 pain medication. R1's care plan also identified risk for alteration of skin status. Interventions included ensuring protective skin measures (barrier cream to dry areas and wheelchair cushion) were in place. R1's physician orders included an order for miconazole nitrate 2% topical cream (antifungal cream used to treat fungal or yeast infections) with start date 10/29/24 and discontinue date 5/15/25. Instructions were to apply to affected area topically twice daily scheduled for administration once between 7:00 a.m. and 3:00 p.m. (day) and again between 3:00 p.m. and 11:00 p.m. (evening). R1's physician orders included an order for tramadol oral tablet (an opioid pain medication used to treat moderate to moderately severe pain) 50 milligrams (mg) strength with start date 1/30/25. Instructions were to administer 25 mg orally four times a day for pain scheduled for administration at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R1's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled twice daily administrations of miconazole. Documentation of the miconazole as "not administered" included: - 3/1/25 day and evening doses with notes "drug/item unavailable" - 3/3/25 evening dose with comment "on order" - 3/6/25 evening dose with note "drug/item unavailable" - 3/7/25 day and evening doses with notes "drug/item unavailable" - 3/8/25 day dose with note "drug/item unavailable"	F 755	All residents have the potential to be affected. Medications are being administered per provider's orders. Medication error process is being followed. Education completed with nurses regarding updating the provider and pharmacy if a medication is unavailable and following medication error process. Medications unavailable will be audited for 10 residents per week for a 24hr lookback for 4 weeks, followed by 6 residents per week for 4 weeks, then 4 residents per week for 4 weeks. Audit results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Date of compliance: 6.17.2025	

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F 755	Continued From page 34 - 3/15/25 day dose with note "drug/item unavailable" - 4/4/25 evening dose with note "drug/item unavailable" - 4/5/25 day and evening doses with notes "drug/item unavailable" - 4/6/25 day and evening doses with notes "drug/item unavailable" - 4/7/25 day dose with note "drug/item unavailable" - 4/24/25 evening dose with note "drug/item unavailable" - 4/25/25 day and evening doses with notes "drug/item unavailable" - 4/26/25 day and evening doses with notes "drug/item unavailable" - 5/2/25 day and evening doses with notes "drug/item unavailable" - 5/4/25 day dose with note "drug/item unavailable" - 5/7/25 day dose with note "drug/item unavailable" R1's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled four daily administrations of tramadol. Documentation of the tramadol as "not administered" included: - 4/11/25 at 4:00 p.m. with note "drug/item unavailable" - 4/24/25 at 8:00 p.m. with note "med[ication] not here called pharmacy" - 4/25/25 at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. with notes "drug/item unavailable" - 4/26/25 at 8:00 a.m., 12:00 p.m., and 4:00 p.m. with notes "drug/item unavailable" R1's progress notes dated 4/24/25 at 6:45 p.m. and 6:55 p.m., indicated insurance would not	F 755		

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F 755	Continued From page 35 cover the current dose of tramadol and wanted to change the dose. The pharmacy sent a fax to the facility to change the tramadol orders, R1 had no more tramadol available, and the on-call provider was notified. The on-call provider approved the pharmacy changing the tramadol order with new order for 50 mg tablets, give half tablet four times daily and once daily as needed for pain. Per pharmacy, insurance would cover this dose. Review of R1's progress notes did not identify further documentation regarding availability of the tramadol or miconazole, missed administrations, or related provider notifications. On 5/15/25 at 11:53 a.m., licensed practical nurse (LPN)-A stated on 4/24/25, R1 only had one remaining tramadol tablet. She contacted the pharmacy to re-order, was told R1's insurance would no longer cover this tablet, and contacted the on-call provider for approval to change from 25 mg tablets to 50 mg tablets cut in half. LPN-A stated she notified the provider to get approval, but did not notify the provider of the missed dose at 8:00 p.m. when the medication was unavailable because she assumed the medication would arrive later that night after her shift ended. LPN-A stated if a medication was not administered, the physician should be notified and missed doses of medications without a provider order to hold were medication errors. LPN-A noted R1's miconazole had been discontinued earlier that morning because she did not use it and would say she didn't want it at times. LPN-A stated she would document medications as not administered with note that drug/item was unavailable when a medication was not available and would then call the pharmacy. LPN-A confirmed she was R1's nurse	F 755		

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F 755	Continued From page 36 and in charge of the medication cart with R1's medications. During observation, LPN-A searched R1's medications in the cart, house stock medications in the cart, R1's room, and the medication room for R1's miconazole cream. LPN-A confirmed she had not removed it from the cart for disposal and was not able to locate the medication. LPN-A confirmed this was a physician ordered medication and should be available, thought noted there had been a lack of supply previously. During an interview on 5/15/25 at 8:15 a.m., the director of nursing (DON) stated medications should be available for administration as ordered. If a medication was not available, the provider should be notified. If a medication was not available and staff failed to obtain a provider order to hold (not give) the medication, it would be a medication error. The DON stated she was not aware of R1's missed administrations of miconazole and tramadol. The DON stated if the tramadol was not given and the provider did not give an order to hold it, it would be considered a medication error. She stated she would expect R1's miconazole cream to be in stock and available for administration, would expect the provider to be notified if it was not, and would consider the missed administrations to be medication errors. The DON reviewed facility medication administration error reports and confirmed there were no medication errors reported for R1 between 3/1/25 and 5/13/25. During an interview on 5/15/25 at 10:46 a.m., the DON stated on 4/24/25 at 4:00 p.m. R1 received the last dose of her available tramadol, which was in 25 mg tablet form. On 4/24/25, staff were informed by the pharmacy that the 25 mg tablets	F 755		

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F 755	Continued From page 37 would no longer be covered by insurance and got provider approval to change the prescription to half of a 50 mg tablet. R1 did not receive the medication again until 4/26/25 at 8:00 p.m. The DON stated she saw no indication the provider was notified of the ongoing lack of medication supply or missed administrations and would be processing this as a medication error. R2 R2's MDS dated 3/9/25, indicated he admitted to the facility on 12/3/24 with diagnoses including chronic obstructive pulmonary disease (COPD). R2's care plan revised 2/6/25, identified R2's goal of care was comfort focused. Interventions included medications, treatments, and cares as ordered by primary physician and nurse practitioner. R2's physician orders included an order for albuterol sulfate aerosol inhaler 90 micrograms (mcg) per actuation with start date 12/3/24. Instructions were to inhale two puffs four times a day for COPD scheduled for administration at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. R2's provider visit note dated 5/13/25, indicated he had a history of COPD with previous hospitalizations for pneumonia and COPD exacerbation. The note indicated R2's COPD was managed with medications including two puffs of an albuterol inhaler four times a day. R2's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled four daily administrations of albuterol. Documentation of the albuterol as "not administered" included: 4/2/25 at 4:00 p.m. and	F 755		

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F 755	Continued From page 38 8:00 p.m. with note "drug/item unavailable" Review of R2's progress notes did not identify documentation regarding availability of the albuterol inhaler, missed administrations, or related provider notifications. During an interview on 5/15/25 at 2:20 p.m., the DON confirmed documentation reflected two missed doses of albuterol on 4/2/25 with notes that it was unavailable. The DON stated she was not informed of this and did not see it in the facility's medication error reports. The DON stated she would expect it to be identified as a medication error and to be reported to the provider. The DON noted the medication was not administered in accordance with physician orders. Facility policy titled Administering Medications dated 8/31/23, included "2.) Medications are administered in accordance with the orders. 3.) Medications are administered within their prescribed time. 4.) The person preparing or administering the medication will contact the provider if there are questions or concerns regarding medication. 5.) With any irregularities, appropriate notifications will be completed for clarification." Facility policy titled Medication Error/Occurrence dated 8/31/23, included definition of a medication error as "the preparation or administration of drugs or biologicals which is not in accordance with the attending providers' orders, manufacturer's specification or accepted standards and principles of the professional providing the services." Examples of medication errors included "omissions." The policy included	F 755		

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F 755	Continued From page 39 "When an error is made in the preparation or administration of a drug or biological, the licensed nurse provides any necessary immediate care and notifies the attending provider and resident or resident representative when nursing or medical intervention, observation or treatment is indicated. Medication errors are tracked and trended for quality improvement purposes ... Insignificant medication errors such as a missed vitamin C will be internally investigated and may not be reported as nursing or medical treatment is not necessary. Frequent nonsignificant errors will require additional process investigation and performance improvement interventions including notification to the medical director. The licensed nurse and/or nurse supervisor may notify the attending physician and resident/resident representative of medication errors as deemed appropriate ... Documentation includes the date, time of the error or discovery of error, the resident's condition, including vital signs, notification of provider, medical orders and notification of the resident/resident representative."	F 755		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide adaptive eating utensils according to the care plan for 1 of 1	F 810	Statement of credible allegation (can use in MN, WI, MO)	6/17/25

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F 810	Continued From page 40 resident (R7) reviewed for nutrition. Findings include R7's face sheet dated 5/16/25, identified diagnosis of rheumatoid arthritis (a chronic inflammatory disorder affecting joints in hands or feet). R7's Minimum Data Set (MDS) dated 4/25/25, identified R7 was independent in eating and had intact cognition. R7's nutritional status focus care plan dated 5/7/25, identified a potential for altered nutrition related to rheumatoid arthritis, with an intervention of built-up utensils with all meals and culinary to provide. R7's nursing assistant care sheet dated 5/15/25, identified that R7 needed built-up utensils provided by the kitchen. R7's daily meal cards dated 5/15/25, identified R7 was to have built up utensils for all meals. R7's registered dietician progress note dated 3/6/25, identified R7 has continued to need built-up silverware to help with self-feeding related to rheumatoid arthritis. R7's grievance dated 3/21/25, identified R7 was not getting her built-up silverware with meals as ordered. An undated action identified culinary staff were educated on need to include built up silverware on meal tray. During an observation and interview on 5/15/25 at 12:54 p.m., R7 was in her room eating her meal	F 810	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F810 Assistive Devices □ Eating Equipment /Utensils R7 is receiving adaptive eating utensils according to care plan. Residents with adaptive eating equipment are receiving equipment per care plan. Education completed with dietary and nursing regarding ensuring residents receive the proper adaptive eating equipment with meal service. Adaptive equipment audits will be completed on nine resident meals weekly for four weeks, then six resident meals weekly for four weeks, then three resident meals weekly for four weeks. Audit results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Date of compliance: 6.17.2025	

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F 810	Continued From page 41 of a pizza slice with a lettuce salad. R7 stated, "How am I supposed to eat my salad without my built-up silverware." R7 was supposed to get them with all her meals, however had not received them in a long time." R7 stated her right hand did not work very well due to her rheumatoid arthritis and she had difficulty holding onto a regular utensils. R7 explained without having built up silverware she just uses her fingers to eat her salad. During an interview on 5/15/25 at 1:27 p.m., licensed practical nurse (LPN)-C confirmed R7 did not receive built-up silverware for her noon meal and was supposed to be having them placed on her tray for each meal. LPN-C further stated the dietary department has been educated on making sure they are place; however, it continues to be a problem. During an interview on 5/15/25 at 4:36 p.m., registered nurse regional director (RNRD) stated her expectation would be for dietary staff to follow the directions on the menu card and supply residents with the adaptive silverware if listed on the tray card for all meals. Review of the facility's Scope of Meal Service Policy undated, identified all culinary services personnel are responsible for the accuracy of tray assembly and all utensils are placed on the resident's tray.	F 810		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		6/17/25

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F 842	Continued From page 42 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or	F 842		

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F 842	Continued From page 43 unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain a complete, accurately documented, and readily accessible medical record in accordance with accepted professional standards and practices for 2 of 3 residents (R2, R3) reviewed for documentation. Findings include: R2 R2's facesheet indicated he admitted to the facility on 12/3/24. R2's electronic health record (EHR) was reviewed on 5/15/25. The EHR lacked any primary care	F 842	Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	

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F 842	Continued From page 44 provider (medical doctor, nurse practitioner, or physician assistant) visit notes from R2's current admission starting 12/3/24. During an interview on 5/15/25 at 10:46 a.m., the director of nursing (DON) confirmed there were no primary care provider visit notes in R2's EHR. R2's primary care provider visit notes were retrieved from the primary care provider's external medical records system by facility staff. Visit notes provided to surveyors absent from the facility's EHR included eight total visits from dates: 12/4/24, 12/17/24, 12/24/24, 1/7/25, 2/19/25, 3/25/25, 4/2/25, and 5/13/25. R3 R3's facesheet indicated she admitted to the facility on 8/29/24. R3's EHR was reviewed on 5/14/25. The EHR lacked any primary care provider visit notes from R3's current admission starting 8/29/24. During an interview on 5/14/25 at 4:45 p.m., the DON confirmed there were no primary care provider visit notes in R2's EHR. R3's primary care provider visit notes were retrieved from the primary care provider's external medical records system by facility staff. Visit notes provided to surveyors absent from the facility's EHR included 17 total visits from dates: 9/3/24, 9/4/24, 9/10/24, 9/17/24, 9/24/24, 9/25/24, 10/8/24, 11/20/24, 11/26/24, 12/10/24, 12/24/24, 1/14/25, 1/29/25, 2/25/25, 3/5/25, 4/8/25, and 5/3/25. During an interview on 5/14/25 at 4:45 p.m., the	F 842	R2 and R3 primary care visit notes are in the electronic health record. All residents' medical records were audited to ensure primary care visit notes are uploaded in the electronic health record and will be maintained ongoing. Nurses and Health Information staff have been educated regarding uploading primary care visit notes in the electronic health record. The Health Information staff now have access to the provider portal to retrieve the necessary documents for uploading, and all 3 staff receive email notification when new portal documents are ready for retrieval. The uploading of resident primary care visit notes will be audited on five residents weekly for four weeks, then three residents for four weeks, then one resident for four weeks. Audit results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Date of compliance: 6.17.2025	

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F 842	Continued From page 45 DON stated primary care provider notes were handled by medical records who uploaded visit notes into resident EHRs. The DON stated she would expect to see provider notes uploaded in the EHR and it was important to have complete and accurate information about a resident. She would not consider a medical record complete and accurate without primary provider visit notes and this did not meet her expectations. The DON was not aware of a specific time frame within which notes should be uploaded but would guess within a month. During an interview on 5/14/25 at 5:22 p.m., the administrator stated she would expect provider notes to be in resident EHRs. The administrator noted this mattered because staff needed access to reference them and they were needed in case of an emergency. The administrator was not aware there were resident EHRs that contained no primary care provider notes. She would expect notes to be uploaded into EHRs as soon as they were received by the facility. Facility policy titled Charting and Documentation in the Medical Record dated 10/4/23, indicated the purpose was to ensure objective, accurate, timely and clinically complete information in the individual resident medical record. Information to be documented in the resident medical record included: Objective observations; Medications administered; Treatments or services performed; Changes in the resident's condition; Events, incidents or accidents involving the resident; Progress toward the care plan goals; other communication with resident representative. The policy indicated documentation in the medical record would be objective, complete, and accurate.	F 842		

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F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to	F 867		6/17/25

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F 867	Continued From page 47 prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms	F 867		

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F 867	Continued From page 48 that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded	F 867	Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the	

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F 867	Continued From page 49 to excessively long call light response times by developing and implementing action plans for process improvement identified to be a current concern with past identified non compliancy. This had the potential to affect all 81 residents who resided in the facility. Findings include: The facility's QAPI Program Plan dated September 2024, identified the purpose of the quality program was to provide quality and performance excellence in care and service delivery. The plan included various areas of care and service with an ongoing process to select and monitor data. Quality focus areas identified by both the facility and community included regulatory compliance and customer concerns. Data was collected for regulatory compliance from CMS-2567 forms as it occurred and the threshold (level of performance that requires a reaction) was identified as compliance. Customer concern data was collected monthly from residents/families/guests with threshold of 90% or lower resolved in five days. The program's systematic analysis and systemic action included systematically analyzing underlying causes of systemic quality issues, developing/implementing quality improvement activities, and monitoring the effectiveness of actions. The Quality Council was noted to fulfill the role of the community's quality assessment and assurance committee and assumed responsibility for identifying and responding to quality deficiencies throughout the community. Additionally, the council developed and implemented corrective actions, monitored to ensure performance goals or targets were achieved, and revised corrective action when	F 867	facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. The facility has developed and implemented an action plan for identified performance improvement as it relates to call light times. On-going QAPI plans will include all elements needed including investigating, analyzing data, and developing action items. During QAPI, the following reports will be reviewed, census report (average census, total admissions, total discharges), rehab report (length of stay, discharge destinations, functional improvement measures), human resources (turnover report, number of workman□s comp cases, and PBJ), emergency preparedness (after event review tabletop/drill status), EMR (downtime reports), Social Services report(discharges, safe transitions, concerns), clinical services (clinical trending reports(falls/falls with injury, PU/Skin, Hospital, Transfers, other)), infection prevention(immunizations, statistical report, flu/COVID activity report), pharmacy report (medication utilization statistics, drug regimen review),	

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F 867	Continued From page 50 necessary. The facility's Quality Council meeting PowerPoint for March 2025 with corresponding meeting minute notes identified the council met on 3/25/25 to review data from February 2025. The PowerPoint included a slide titled MDH-Survey Plan of Correction/Audits which identified citation from annual survey with plan of correction dated 1/15/25 including F725 sufficient nursing staff. A slide titled Concerns identified there were zero concerns for the month related to call light issues. The PowerPoint and meeting notes lacked further information about the audits and did not identify the details of the data collected. There was no investigation or causal analysis of the data, specific related goal, identified action plan, or monitoring of effectiveness of the facility's related actions. The facility's Quality Council meeting PowerPoint for April 2025 with corresponding meeting minute notes identified the council met on 4/22/25 to review data from March 2025. The PowerPoint included a slide titled MDH-Survey Plan of Correction/Audits which identified citation from annual survey with plan of correction dated 1/15/25 including F725 sufficient nursing staff. A slide titled Concerns identified there were 19 total concerns for the month including 3 related to call light issues. The PowerPoint and meeting notes lacked further information about the audits or call light and did not identify the details of the data collected (audits completed and 3 concerns). There was no investigation or causal analysis of the data, specific related goal, identified action plan, or monitoring of effectiveness of the facility's related actions.	F 867	dietary report (sanitation inspections, monthly report), and maintenance/environmental services updates. Following the data, discussion will occur related to the following questions: Have we determined the root cause(s) of the problem we are attempting to solve?, What systemic changes are needed?, How are we monitoring our progress?, Are we making progress toward our goal?, Is there a need for additional resources?, Are there constraints or barriers to our progress?. Following the discussion, the QAPI Committee will discuss actions: What actions will we need to take to reach the goal?, Who is responsible for each action?, What is the completion date for each action?, How will we communicate (to others) the outcomes of our Process Improvement Projects?. If there is an area of concern brought forward, an immediate correction will happen, and if needed a process improvement plan will be implemented. Administrator attended Benedictine Quality Training on June 3rd and 4th, 2025. QAPI Commitee was educated by the Regional Director of Clinical Services on Benedictine□s Quality Assurance Performance Improvement Tool Kit, Policy, and Performance Improvement Plans. Facility process improvement plans will be audited by the Regional Director of Clinical Services once a week for 12 weeks to ensure the facility is actively	

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F 867	Continued From page 51 The facility's grievance log dated 2/20/25 through 5/12/25, included call light grievances related to staff response times. Grievances included: - On 3/25/25, a resident expressed concern that he put his call light on, waited 30 minutes with no response, and then went to the nursing station to ask staff for assistance. - On 4/1/25, a resident stated at night she had to wait over an hour for someone to answer her call light. - On 4/14/25, a resident stated when she put her call light on for toileting it was not answered fast enough, and she had to go in her brief. - On 4/14/25, a resident stated he put his call light on at 2:00 am and a staff member answered the light, turned the light off, left the room, and did not address his needs. - On 4/26/25, a resident reported she put her call light on and waited over an hour for staff to respond. Facility audit sheets titled F725 Sufficient Nursing Staff: Call Light Times included columns titled date, resident, shift being audited, were call lights answered timely, does resident have any concerns with call light times, and comments. Completed audit sheets were dated from 2/25/25 through 5/7/25. During an interview on 5/14/25 at 5:22 p.m., the administrator stated each nurse manager had been completing audits each week on a variety of shift. The administrator stated currently one resident and one shift was being audited each week, and the resident and shift had been picked at random. The administrator stated she had not heard of any concerns identified on the audits but had reviewed call light logs requested by surveyors and the data reflected in the call light	F 867	working on their plans and reviewing them with the QAPI Committee during the monthly meeting. The Regional Director of Clinical Services will be attending QAPI monthly to ensure the process is being followed per Benedictine policy. The need for ongoing monitoring will be determined by regional review of audits. Date of compliance: 6.17.2025	

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F 867	Continued From page 52 logs did not align with what was recorded on the audit sheets. The administrator stated no specific direction was given to nurse managers when completing the audits, such as what constituted answering a call light timely, and they just followed the prompts in the column titles. She noted the QAPI committee met monthly and reviewed reportable incidents from the prior month, current plans of correction being worked though, admission data, quality improvement program data, return to hospital data, medication errors, skin issues, falls, behavior management, concerns from the prior month, nutrition and weight data, human resources data, and "anything else relevant at the time." The administrator stated "call light logs have not been included in QAPI" and noted they were listed under the current audits the facility was doing and "there hasn't been concerns in the actual audits." The administrator stated call lights had not been identified as on ongoing concern. During an interview on 5/15/25 at 8:15 a.m., the director of nursing (DON) stated she was aware call lights were an ongoing problem because of concerns and reports from residents. The DON stated data regarding call light times was monitored through the audits and resident concerns, like grievances filed. The DON reviewed the facility's call light logs dated 2/25/25 through 5/7/25. She identified some audits were marked "see attached" and did not specify if the light was answered timely or the resident had concerns, some audits stated lights were answered timely but included call light logs with times that did not meet her expectations for timeliness, and some audits were not completed fully. The DON stated the audits were not complete or accurate, did not specify what	F 867		

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F 867	Continued From page 53 constituted timeliness, and did not include analysis of the data. The DON was unable to articulate how the facility was analyzing data and monitoring the call light times when the data collected was not complete or accurate and stated "we weren't doing that effectively." She noted call light data came from audits and grievances and would be analyzed prior to and reviewed at QAPI meetings. She confirmed the QAPI meeting slide for plans of correction did not include data. After reviewing the call light audit sheets, she stated the data in the audits identified ongoing concerns and noted "I don't see inclusion or analysis of the data or development of an improvement plan" in the QAPI committee meetings. She further noted there was "no analysis of the causal factor of action plan that I'm aware of" and identified the administrator as the person who had been more involved and would know more. During and interview on 5/15/25 at 3:39 p.m., the administrator stated call lights were identified as an issue and the facility was cited for this in January. The plan to monitor and ensure compliance was nurse managers completing call light audits weekly, though she stated the audits were not complete or accurate. The administrator stated audits were analyzed by the nurse managers completing them, the DON, and herself and they did not identify the call light times as continued issue through the audits but "they should have." She stated call light time data had not been analyzed in QAPI and a causal analysis had not been completed. The administrator stated the QAPI committee meeting showed the audits were being done and identified the number of related grievances, but "we need to do more a deep dive into the why's behind them." She	F 867		

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	245255	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 867	Continued From page 54 confirmed there was no action plan for process improvement based on the data and no measurable goal for call light times. She stated, "the goal was 15 minutes, but it is not identified." Facility policy titled Call Lights - Call System Activation and Response dated 5/28/24, included "Call light response times are reviewed as part of the QAPI program." Facility policy titled Quality Council (Quality Assessment and Assurance Committee) undated, indicated the facility had a Quality Council. The Quality Council "assumes responsibility and oversight for services related to resident safety, health outcomes, resident autonomy, choice, quality of care, as well as customer satisfaction, regulatory compliance, and related performance improvement. The community will develop a plan to promote excellence in quality of care, quality of life, resident choice and person directed care. To accomplish this all employees are empowered to participate in ongoing QAPI efforts which support our mission. The Quality Council will collect and utilize data related to the unique characteristics and needs of the patients, focusing on high risk, problem prone, and high-volume areas to develop their annual QAPI plan. The Quality Council serves as the Community's Quality Assessment and Assurance (QAA) Committee with oversight of the Quality Assurance and Process Improvement (QAPI) program." Procedure included, "The Quality Assessment and Assurance committee Plan describes the process for identifying and correcting quality deficiencies and includes: a) Tracking and measuring performance; b) Establishing goals and thresholds for performance improvement; c) Evaluation of the care and services provided; d)	F 867		

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F 867	Continued From page 55 Identifying and prioritizing quality deficiencies and opportunities for improvement; e) Systematically analyzing underlying causes of systemic quality deficiencies; f) Developing and implementing corrective action or performance improvement activities; g) Monitoring and/or evaluating the effectiveness of corrective action and performance improvement activities and revising as indicated; h) The QAA plan will be reviewed annually and with any significant change to the community."	F 867		

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	00538	A. BUILDING: _____ B. WING _____	05/15/2025

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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 5/12/25 through 5/15/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52553807C (MN112647), H52554390C (MN112659), H52554389C (MN111814), H52554391C (MN111735), H52554608C (MN112977), & H52554609C (MN112997) with licensing orders issued at 0255, 0625, 0800, 0945, & 1545. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded to excessively long call light response times by	2 255	Corrected	6/17/25

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2 255	Continued From page 3 developing and implementing action plans for process improvement identified to be a current concern with past identified non compliancy. This had the potential to affect all 81 residents who resided in the facility. Findings include: The facility's QAPI Program Plan dated September 2024, identified the purpose of the quality program was to provide quality and performance excellence in care and service delivery. The plan included various areas of care and service with an ongoing process to select and monitor data. Quality focus areas identified by both the facility and community included regulatory compliance and customer concerns. Data was collected for regulatory compliance from CMS-2567 forms as it occurred and the threshold (level of performance that requires a reaction) was identified as compliance. Customer concern data was collected monthly from residents/families/guests with threshold of 90% or lower resolved in five days. The program's systematic analysis and systemic action included systematically analyzing underlying causes of systemic quality issues, developing/implementing quality improvement activities, and monitoring the effectiveness of actions. The Quality Council was noted to fulfill the role of the community's quality assessment and assurance committee and assumed responsibility for identifying and responding to quality deficiencies throughout the community. Additionally, the council developed and implemented corrective actions, monitored to ensure performance goals or targets were achieved, and revised corrective action when necessary. The facility's Quality Council meeting PowerPoint	2 255		

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2 255	Continued From page 4 for March 2025 with corresponding meeting minute notes identified the council met on 3/25/25 to review data from February 2025. The PowerPoint included a slide titled MDH-Survey Plan of Correction/Audits which identified citation from annual survey with plan of correction dated 1/15/25 including F725 sufficient nursing staff. A slide titled Concerns identified there were zero concerns for the month related to call light issues. The PowerPoint and meeting notes lacked further information about the audits and did not identify the details of the data collected. There was no investigation or causal analysis of the data, specific related goal, identified action plan, or monitoring of effectiveness of the facility's related actions. The facility's Quality Council meeting PowerPoint for April 2025 with corresponding meeting minute notes identified the council met on 4/22/25 to review data from March 2025. The PowerPoint included a slide titled MDH-Survey Plan of Correction/Audits which identified citation from annual survey with plan of correction dated 1/15/25 including F725 sufficient nursing staff. A slide titled Concerns identified there were 19 total concerns for the month including 3 related to call light issues. The PowerPoint and meeting notes lacked further information about the audits or call light and did not identify the details of the data collected (audits completed and 3 concerns). There was no investigation or causal analysis of the data, specific related goal, identified action plan, or monitoring of effectiveness of the facility's related actions. The facility's grievance log dated 2/20/25 through 5/12/25, included call light grievances related to staff response times. Grievances included: - On 3/25/25, a resident expressed concern that	2 255		

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2 255	Continued From page 5 he put his call light on, waited 30 minutes with no response, and then went to the nursing station to ask staff for assistance. - On 4/1/25, a resident stated at night she had to wait over an hour for someone to answer her call light. - On 4/14/25, a resident stated when she put her call light on for toileting it was not answered fast enough, and she had to go in her brief. - On 4/14/25, a resident stated he put his call light on at 2:00 am and a staff member answered the light, turned the light off, left the room, and did not address his needs. - On 4/26/25, a resident reported she put her call light on and waited over an hour for staff to respond. Facility audit sheets titled F725 Sufficient Nursing Staff: Call Light Times included columns titled date, resident, shift being audited, were call lights answered timely, does resident have any concerns with call light times, and comments. Completed audit sheets were dated from 2/25/25 through 5/7/25. During an interview on 5/14/25 at 5:22 p.m., the administrator stated each nurse manager had been completing audits each week on a variety of shift. The administrator stated currently one resident and one shift was being audited each week, and the resident and shift had been picked at random. The administrator stated she had not heard of any concerns identified on the audits but had reviewed call light logs requested by surveyors and the data reflected in the call light logs did not align with what was recorded on the audit sheets. The administrator stated no specific direction was given to nurse managers when completing the audits, such as what constituted answering a call light timely, and they just	2 255		

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2 255	Continued From page 6 followed the prompts in the column titles. She noted the QAPI committee met monthly and reviewed reportable incidents from the prior month, current plans of correction being worked though, admission data, quality improvement program data, return to hospital data, medication errors, skin issues, falls, behavior management, concerns from the prior month, nutrition and weight data, human resources data, and "anything else relevant at the time." The administrator stated "call light logs have not been included in QAPI" and noted they were listed under the current audits the facility was doing and "there hasn't been concerns in the actual audits." The administrator stated call lights had not been identified as on ongoing concern. During an interview on 5/15/25 at 8:15 a.m., the director of nursing (DON) stated she was aware call lights were an ongoing problem because of concerns and reports from residents. The DON stated data regarding call light times was monitored through the audits and resident concerns, like grievances filed. The DON reviewed the facility's call light logs dated 2/25/25 through 5/7/25. She identified some audits were marked "see attached" and did not specify if the light was answered timely or the resident had concerns, some audits stated lights were answered timely but included call light logs with times that did not meet her expectations for timeliness, and some audits were not completed fully. The DON stated the audits were not complete or accurate, did not specify what constituted timeliness, and did not include analysis of the data. The DON was unable to articulate how the facility was analyzing data and monitoring the call light times when the data collected was not complete or accurate and stated "we weren't doing that effectively." She	2 255		

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2 255	Continued From page 7 noted call light data came from audits and grievances and would be analyzed prior to and reviewed at QAPI meetings. She confirmed the QAPI meeting slide for plans of correction did not include data. After reviewing the call light audit sheets, she stated the data in the audits identified ongoing concerns and noted "I don't see inclusion or analysis of the data or development of an improvement plan" in the QAPI committee meetings. She further noted there was "no analysis of the causal factor of action plan that I'm aware of" and identified the administrator as the person who had been more involved and would know more. During and interview on 5/15/25 at 3:39 p.m., the administrator stated call lights were identified as an issue and the facility was cited for this in January. The plan to monitor and ensure compliance was nurse managers completing call light audits weekly, though she stated the audits were not complete or accurate. The administrator stated audits were analyzed by the nurse managers completing them, the DON, and herself and they did not identify the call light times as continued issue through the audits but "they should have." She stated call light time data had not been analyzed in QAPI and a causal analysis had not been completed. The administrator stated the QAPI committee meeting showed the audits were being done and identified the number of related grievances, but "we need to do more a deep dive into the why's behind them." She confirmed there was no action plan for process improvement based on the data and no measurable goal for call light times. She stated, "the goal was 15 minutes, but it is not identified." Facility policy titled Call Lights - Call System Activation and Response dated 5/28/24, included	2 255		

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2 255	Continued From page 8 "Call light response times are reviewed as part of the QAPI program." Facility policy titled Quality Council (Quality Assessment and Assurance Committee) undated, indicated the facility had a Quality Council. The Quality Council "assumes responsibility and oversight for services related to resident safety, health outcomes, resident autonomy, choice, quality of care, as well as customer satisfaction, regulatory compliance, and related performance improvement. The community will develop a plan to promote excellence in quality of care, quality of life, resident choice and person directed care. To accomplish this all employees are empowered to participate in ongoing QAPI efforts which support our mission. The Quality Council will collect and utilize data related to the unique characteristics and needs of the patients, focusing on high risk, problem prone, and high-volume areas to develop their annual QAPI plan. The Quality Council serves as the Community's Quality Assessment and Assurance (QAA) Committee with oversight of the Quality Assurance and Process Improvement (QAPI) program." Procedure included, "The Quality Assessment and Assurance committee Plan describes the process for identifying and correcting quality deficiencies and includes: a) Tracking and measuring performance; b) Establishing goals and thresholds for performance improvement; c) Evaluation of the care and services provided; d) Identifying and prioritizing quality deficiencies and opportunities for improvement; e) Systematically analyzing underlying causes of systemic quality deficiencies; f) Developing and implementing corrective action or performance improvement activities; g) Monitoring and/or evaluating the effectiveness of corrective action and performance improvement activities and revising	2 255		

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2 255	Continued From page 9 as indicated; h) The QAA plan will be reviewed annually and with any significant change to the community." SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these areas on a regular basis and make recommendations for changes as needed. The administrator will be responsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with	2 625		6/17/25

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2 625	Continued From page 10 religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to maintain a complete, accurately documented, and readily accessible medical record in accordance with accepted professional standards and practices for 2 of 3 residents (R2, R3) reviewed for documentation. Findings include:	2 625	Corrected	

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2 625	Continued From page 11 R2 R2's facesheet indicated he admitted to the facility on 12/3/24. R2's electronic health record (EHR) was reviewed on 5/15/25. The EHR lacked any primary care provider (medical doctor, nurse practitioner, or physician assistant) visit notes from R2's current admission starting 12/3/24. During an interview on 5/15/25 at 10:46 a.m., the director of nursing (DON) confirmed there were no primary care provider visit notes in R2's EHR. R2's primary care provider visit notes were retrieved from the primary care provider's external medical records system by facility staff. Visit notes provided to surveyors absent from the facility's EHR included eight total visits from dates: 12/4/24, 12/17/24, 12/24/24, 1/7/25, 2/19/25, 3/25/25, 4/2/25, and 5/13/25. R3 R3's facesheet indicated she admitted to the facility on 8/29/24. R3's EHR was reviewed on 5/14/25. The EHR lacked any primary care provider visit notes from R3's current admission starting 8/29/24. During an interview on 5/14/25 at 4:45 p.m., the DON confirmed there were no primary care provider visit notes in R2's EHR. R3's primary care provider visit notes were retrieved from the primary care provider's external medical records system by facility staff. Visit notes provided to surveyors absent from the facility's EHR included 17 total visits from dates:	2 625		

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2 625	Continued From page 12 9/3/24, 9/4/24, 9/10/24, 9/17/24, 9/24/24, 9/25/24, 10/8/24, 11/20/24, 11/26/24, 12/10/24, 12/24/24, 1/14/25, 1/29/25, 2/25/25, 3/5/25, 4/8/25, and 5/3/25. During an interview on 5/14/25 at 4:45 p.m., the DON stated primary care provider notes were handled by medical records who uploaded visit notes into resident EHRs. The DON stated she would expect to see provider notes uploaded in the EHR and it was important to have complete and accurate information about a resident. She would not consider a medical record complete and accurate without primary provider visit notes and this did not meet her expectations. The DON was not aware of a specific time frame within which notes should be uploaded but would guess within a month. During an interview on 5/14/25 at 5:22 p.m., the administrator stated she would expect provider notes to be in resident EHRs. The administrator noted this mattered because staff needed access to reference them and they were needed in case of an emergency. The administrator was not aware there were resident EHRs that contained no primary care provider notes. She would expect notes to be uploaded into EHRs as soon as they were received by the facility. Facility policy titled Charting and Documentation in the Medical Record dated 10/4/23, indicated the purpose was to ensure objective, accurate, timely and clinically complete information in the individual resident medical record. Information to be documented in the resident medical record included: Objective observations; Medications administered; Treatments or services performed; Changes in the resident's condition; Events, incidents or accidents involving the resident;	2 625		

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2 625	Continued From page 13 Progress toward the care plan goals; other communication with resident representative. The policy indicated documentation in the medical record would be objective, complete, and accurate. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on the maintenance of resident medical records. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure each resident's clinical record is complete and accurate and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 800	Corrected	6/17/25

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2 800	Continued From page 14 review, the facility failed to provide sufficient staffing to ensure residents received the care and assistance they needed in a timely manner for 4 of 5 residents (R5, R1, R3, & R6) reviewed for call lights. This caused actual harm to R5 when she waited nearly three hours for her call light to be answered causing her to experience increased anxiety, distress, fear, and feelings of worthlessness and helplessness. Findings include: R5 R5's Minimum Data Set (MDS) assessment dated 3/30/25, indicated she had intact cognition and no behaviors or rejections of care. R5 had diagnoses including multiple sclerosis (chronic disease affecting the central nervous system), anxiety disorder, major depressive disorder, and morbid obesity. R5 was frequently incontinent of bowel and bladder and required substantial staff assistance with toileting hygiene, bathing, dressing, and mobility in bed. R5 was dependent on staff for transfers and used a motorized wheelchair independently. R5's urinary incontinence care plan interventions dated 2/11/25, included keep call light within reach, provide incontinence care after each incontinent episode, toilet per request, and staff to toilet every two hours and as needed with extensive assistance. R5's activities of daily living (ADL) care plan included intervention dated 2/11/25, to discuss with staff how to honor R5's preferences and provide care in a timely manner. R5's psychosocial well-being care plan dated 1/15/25, identified potential for trauma related to history of sexual abuse, physical abuse, and mental abuse. Interventions dated 1/15/25 included observe for signs of adjustment	2 800		

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2 800	Continued From page 15 difficulties such as inability to pursue interests or activities or sad or anxious mood. R5's mood state care plan dated 5/26/22 identified R5 was at increased risk for mood issues related to anxiety disorder, suicidal ideations in the setting of delirium, toxic encephalopathy, new an unfamiliar environment, and legal blindness. Intervention dated 5/16/24, noted psychology was to evaluate and treat as needed. R5's psychology provider note by licensed independent clinical social worker (LICSW)-A dated 1/31/25, indicated R5 had diagnoses including major depressive disorder and anxiety disorder. R5's mental status exam noted dysthymic (mild long-lasting depressed) mood, ruminating (persistent negative) thoughts, tearful affect, and tearful behavior. R5 reported an incident of waiting for her brief to be changed after a bowel movement (BM), "which she believes contributed to current UTI [urinary tract infection]." Treatment recommendations included "it remains of benefit for [R5] to have brief changes after BM's as soon as possible, to reduce risk of developing UTI's which she seems to be prone to. This would aid in decreasing anxiety levels." R5's psychology provider note by LICSW-A dated 2/21/25, indicated R5 presented with anxious and depressed mood of sadness, overwhelmed, grief, stress, difficulty concentrating, and fatigue. R5 reported she had another UTI and endorsed anxiety around this. R5's Long Term Care Social Service assessment dated 3/26/25, indicated she had mood appropriate to circumstance and mood was affected by diagnoses. She did not have mood symptoms of depression, crying, or withdrawal	2 800		

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2 800	Continued From page 16 from activities and her mood was not restless, anxious, or inclusive of complaints. R5 was identified as expressing her feelings openly and coping well. She did not distort or misrepresent events, worry/deny/cry, or display ineffective coping skills such as distancing self, anger, or withdrawal from life at facility. The facility's Grievances Log included a grievance entry dated 4/26/25 voiced by R5. The concern section noted R5 reported on Saturday 4/26/25 around 3:00 p.m. she put on her call light for assistance transferring from chair to commode and waited an hour for a nurse to come in. The nurse said she was going to turn the call light off and then back on and let a nursing assistant (NA) know she was waiting. R5 requested the call light not be turned off as she hadn't been assisted yet. Nurse left call light on and informed a NA who then assisted. The findings section of the log noted "The resident's call light was not answered for approximately one hour after activation on Saturday, 4/26, around 3:00 PM. When a nurse eventually responded, she did not provide direct assistance but informed an aide, who later assisted the resident. The nurse initially planned to reset the call light before notifying staff, but the resident requested it remain on until assistance was received." The action section noted "Staff were reminded of the importance of promptly responding to call lights to ensure residents receive timely assistance. Nursing staff were specifically instructed not to reset a call light until the resident's needs have been fully addressed. The situation was reviewed with the care team to reinforce effective communication practices and appropriate procedures for escalating any delays in care. The resident was informed of the concern and the steps being taken to address it."	2 800		

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2 800	Continued From page 17 R5's Device Activity Report (call light log) dated 4/12/25 through 5/14/25, included but was not limited to the following reset times (time from when light is activated to when it is cleared): - 4/12/25 at 7:27 p.m., 20 minutes and 46 seconds - 4/12/25 at 10:40 p.m., 25 minutes and 48 seconds - 4/13/25 at 7:57 a.m., 100 minutes and 22 seconds - 4/15/25 at 2:09 p.m., 21 minutes and 35 seconds - 4/16/25 at 5:05 p.m., 29 minutes and 19 seconds - 4/17/25 at 3:37 p.m., 24 minutes and 32 seconds - 4/19/25 at 7:57 a.m., 23 minutes and 7 seconds - 4/20/25 at 8:50 a.m., 43 minutes and 48 seconds - 4/20/25 at 12:58 p.m., 61 minutes and 51 seconds - 4/20/25 at 9:45 p.m., 22 minutes and 36 seconds - 4/22/25 at 7:38 a.m., 34 minutes and 54 seconds - 4/22/25 at 1:18 p.m., 49 minutes and 30 seconds - 4/22/25 at 9:54 p.m., 28 minutes and 3 seconds - 4/25/25 at 1:16 p.m., 26 minutes and 8 seconds - 4/26/25 at 7:13 a.m., 202 minutes and 18 seconds - 4/26/25 at 3:38 p.m., 64 minutes and 31 seconds - 4/26/25 at 5:50 p.m., 20 minutes and 30 seconds - 4/27/25 at 5:40 p.m., 30 minutes and 14 seconds - 4/28/25 at 6:01 p.m., 32 minutes and 32 seconds	2 800		

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2 800	Continued From page 18 - 5/3/25 at 1:03 p.m., 22 minutes and 52 seconds - 5/6/25 at 7:41 a.m., 57 minutes and 32 seconds - 5/6/25 at 1:00 p.m., 43 minutes and 42 seconds - 5/6/25 at 5:20 p.m., 26 minutes and 2 seconds - 5/7/25 at 7:34 a.m., 24 minutes and 35 seconds - 5/7/25 at 5:57 p.m., 31 minutes and 49 seconds - 5/10/25 at 12:12 p.m., 174 minutes and 8 seconds - 5/11/25 at 12:58 a.m., 20 minutes and 55 seconds - 5/11/25 at 2:12 p.m., 59 minutes and 19 seconds - 5/11/25 at 7:17 p.m., 26 minutes and 51 seconds - 5/12/25 at 3:16 p.m., 31 minutes and 41 seconds - 5/13/25 at 3:24 p.m., 18 minutes and 14 seconds - 5/13/25 at 5:52 p.m., 29 minutes and 34 seconds During an interview on 5/14/25 at 2:19 p.m., R5 stated "there are huge issues with call lights." R5 stated at night sometimes nobody would answer her call light so she would have to use a telephone to call the nursing station on her unit and another unit to request assistance. R5 explained on a good day call lights are answered in 15 minutes, on a bad day anytime between half an hour and 45 minutes, and on a real bad day a lot longer. R5 noted there were occasions she had to wait "marathon times" with the most recent incident on Saturday 5/10/25. R5 stated a nursing assistant (NA) got her up and dressed in the morning and told her the NA assigned to her had left sick an hour into the day shift. The NA who had helped her was then pulled and put on a medication cart to work as a medication aide because they were short a nurse, leaving one NA working the whole floor. R5 stated around 12:15	2 800		

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2 800	Continued From page 19 p.m. she turned her call light on because she needed to have her brief changed. She was sitting in her recliner, it was nice out, and she wanted to go outside. She turned on the light to have her brief changed and transfer to her electric wheelchair to go outside. R5 stated, "no one came until 3:15 in the afternoon, nobody came, not one person to check on me." Review of R5's call light log identified her call light was activated on 5/10/25 at 12:12 p.m. and was not reset for 2 hours 54 minutes and 8 seconds. R5 stated the evening shift NA stopped in her room while orienting another NA who was agency staff and they were not aware her light was on when they came by, but R5 told them what she needed. R5 stated she was a "mell of a hess [sic]" by this point, "I was angry at being ignored, I was terrified that here I am again, and grateful I wasn't in serious physical danger." R5 noted this could have been fatal to somebody so yeah, I'm grateful for that, but I'm afraid, it makes me afraid about being here. I'm never safe here. After she was assisted to the commode she had NAs put her in bed. R5 was afraid by that time, she didn't know who was going to be working that night. She didn't feel comfortable enough to be in her wheelchair and go outside. "I thought just put me in my bed so I can be as safe as possible." R5 noted the facility had been staggering nurses and instead of two nurses starting at 3:00 p.m. they had one start at 3:00 p.m. and one start at 5:00 p.m. which made R5 not feel secure and safe. R5 stated "I don't think emotionally I have recovered" R5 did not feel safe in the late afternoon or early morning because staff don't help. R5 explained another recent instance where she waited an extended time for assistance. R5 had a large BM and had BM all over herself. She informed an NA that she needed assistance because "I know I needed to be changed, and I needed to be	2 800		

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2 800	Continued From page 20 changed fast because I didn't want to have another UTI." R5 indicated the NA told her he needed to finish passing out lunch trays and collecting them and would then get to her. R5 then went to the nursing station and informed staff she needed to be changed now, went back to her room, and turned on her call light. After 15 to 20 minutes, she left her room in her wheelchair to find the NA, told him she needed to be changed now, he stated he had to do something else first, and she returned to her room. After waiting another 15 to 20 minutes she went looking for him again, and he again said he had to go do something in another room. After 15 to 20 more minutes, she found him again and he did it again a third time. R5 stated she "lost it" and went back to my room and she "wept and wailed". After about five minutes, the NA arrived and asked why she was crying and she said because "you won't change me." The NA got a second NA and the two then assisted with cleaning her up. R5 stated she was very upset by this incident. During an interview on 5/15/25 at 12:05 p.m., trained medication aide (TMA)-A stated aides answer call lights and "other staff don't answer call lights, but they should." TMA-A noted it was hard to answer call lights with three aides and sometimes two working. TMA-A stated ten minutes was too long to take to answer a call light and if somebody needs to go to the bathroom they can't wait, "we don't have enough staff to do that." TMA-A stated "with two aides it is a struggle. If we had more staff it would be helpful with call lights. TMA-A noted R5 used the call light when she needed to use the commode or wanted to come out of her room and staff did not have time because two people were needed to transfer R5. TMA-A stated, R5 did get upset about the call light after waiting, "her face changes, she is	2 800		

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2 800	Continued From page 21 mad". During an interview on 5/15/25 at 12:26 p.m., registered nurse (RN)-C stated there were not enough staff to do what needed to be done for the residents and "answer call lights like we should." RN-C stated she thought the recent instance when R5 had to wait approximately three hours for her call light to be answered was sad and "it's obvious how you would feel, neglected, afraid." RN-C explained there should be three aides at all times and noted call lights were more of a problem when there were less than three NA's working on the unit. During an interview on 5/15/25 at 9:50 a.m., staffing coordinator (SC) reviewed the schedule from Saturday 5/10/25 for R5's unit. She noted the day shift had two nurses, an RN from 6:30 a.m. to 1:00 p.m. and an LPN from 6:30 a.m. to 3:00 p.m. The day shift had three NA's working, with two scheduled from 6:30 a.m. to 2:45 p.m. and one scheduled from 6:30 a.m. to 3:00 p.m. The NA scheduled to work until 3:00 p.m. came in for about an hour in the morning, became sick and left, and another NA came in to replace her. The evening shift had two nurses and two NA's. One LPN was scheduled from 3:00 p.m. to 8:00 p.m. and the second LPN scheduled from 4:00 to 11:00 p.m. called out and was replaced by an RN pulled from a different unit. Three NA's were scheduled to work: one from 2:30 p.m. to 11:00 p.m., one from 3:00 p.m. to 11:00 p.m., and one from 3:00 p.m. to 9:00 p.m. Two NA's worked the evening shift as the third was pulled to a different unit to work as a TMA. The SC stated one of the aides from another unit was "probably floating" between their assigned unit and R5's unit. During an interview on 5/15/25 at 4:33 p.m., the	2 800		

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2 800	Continued From page 22 nurse manager for R5's unit, RN-D, stated she didn't know what was going on with call lights, "we need to work on getting those lights." Call lights should be answered in no more than five minutes. If a light was not answered timely a resident would may not feel good about it or disappointed, RN-D noted she "wouldn't be happy." RN-D recalled the instance on 4/26/25 when R5 had to wait an hour for her call light to be answered and thought it was because an aide had been sick and left early. RN-D stated she talked to R5 about this and she was "not happy." Whoever saw the light should have answered right away and it was unacceptable. RN-D had also spoken with R5 about the instance on 5/10/25 when she waited approximately three hours for her call light to be answered and R5 "wasn't happy." Long call lights had a negative effect on residents when they had to wait that long for assistance and it was definitely something we need to work on with the call lights, whether it is a weekend or not. Regarding how long call light times affected R5, RN-D stated she knew for sure R5 did get anxious and worried because R5 had told as much. RN-D stated she had not looked into how call light logs compared to staffing and hadn't heard from her staff that they were related. During an interview on 5/15/25 at 4:00 p.m., the director of social services (DSS) stated long call light wait times "are negative towards people's psychosocial well-being" and could make residents not trust our staff, could impact how people feel about being safe here. The DSS noted some residents could get a lot more anxious if their call lights were not being answered, especially if they already have anxiety. An increase in anxiety would be considered a negative impact to psychosocial well-being. The DSS reviewed her concerns (grievances)	2 800		

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2 800	Continued From page 23 database and noted a concern from R5 on 5/10/25 that her call light was on for three hours and noted staff were still looking into this with nurse manager RN-D assigned to investigate. She identified an additional concern from R5 dated 4/26/25 when she waited for over an hour for her light to be answered which was confirmed when staff reviewed call light logs. The DSS assumed this impacted R5 negatively, could be harmful, and probably increased her anxiety levels. The DSS noted waiting one or three hours for a call light to be answered could impact a resident's sense of dignity or self-worth. She expected call lights to be answered "no later than 20 minutes" and long call light wait times "wouldn't feel good." During a return phone call interview on 5/19/25 at 4:45 p.m., licensed independent clinical social worker (LICSW)-A stated she had been seeing R5 since she admitted to the facility and saw R5 for her depression, chronic adjustment distress, anxiety, and post-traumatic stress symptoms. LICSW-A was aware of R5's long call light times, including the one that took staff three hours to answer. LICSW-A noted in response to the long call light times it made R5 feel helpless, a lack of control, and like her needs don't matter." R5 was reliant on staff to use the bathroom or get transferred. Long call light wait times "certainly impacts her [R5's] anxiety levels." R5's reported three-hour wait time was "a long wait time, I would expect that most people would feel pretty distressed by that. LICSW-A felt R5's distress level and response is completely understandable and appropriate to the situation. LICSW-A also noted R5 had brought up call light wait times with her previously. LICSW-A believed it did impact R5's mood and feeling of lack of being in control of her situation. Additionally, feeling of	2 800		

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	00538	A. BUILDING: _____ B. WING _____	05/15/2025

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2 800	Continued From page 24 helplessness that R5 requested help and not only has it not arrived, but then she has had to wait for that long amount of time. LICSW-A stated for R5 "it kind of filters into her thought of "do my needs matter?"" and when her call light was not answered timely "she feels depressed." R5 "was angry and tearful" when talking about this experience. LICSW-A stated for her to wait that long, that is harmful to her. R5 had filed multiple complaints and grievances and spoken with facility staff and the ombudsman, but there has not been any improvement so she worries. LICSW-A noted R5 had expressed fears about what could happen to her in the time frame while she was waiting for a call light to be answered, and the worry had been "kind of steady." LICSW-A noted adjusting to the facility "has been very difficult for her [R5]" and long call light wait times "doesn't help." LICSW-A noted R5 had been better adjusted over the last year and a half but then if a circumstance like this comes up it brings her back to some of those feelings. R1 R1's MDS assessment dated 2/2/25, indicated she had intact cognition and no behaviors or rejections of care. R1 had diagnoses including Parkinson's disease, acute pain due to trauma, back pain, and abnormalities of gait and mobility. She was occasionally incontinent of urine, and required substantial staff assistance with toileting, bathing, bed mobility, and transfers. R1's mobility care plan dated 3/1/25, identified she needed staff assistance with bed mobility, transfers, ambulation, and locomotion due to immobility. Intervention dated 5/12/25, directed staff to ensure the call light was in reach and encourage R1 to use it to make needs known. R1's urinary care plan with interventions dated	2 800		

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2 800	Continued From page 25 2/11/25, directed staff to keep call light in reach, toilet every two to three hours and as needed, and toilet per request. Her communication care plan dated 2/11/25, identified R1 preferred to have her call light on the table in her room and would also like to have a bell to ring if she needed assistance. Intervention dated 2/11/25, directed to discuss with staff how to honor preferences and provide care in a timely manner. R1's call light log dated 4/12/25 through 5/14/25, included but was not limited to the following reset times: - 4/12/25 at 11:05 a.m., 28 minutes and 46 seconds - 4/12/25 at 5:32 p.m., 33 minutes and 39 seconds - 4/12/25 at 8:24 p.m., 26 minutes and 58 seconds - 4/13/25 at 8:27 a.m., 25 minutes and 25 seconds - 4/13/25 at 9:17 a.m., 32 minutes and 59 seconds - 4/13/25 at 12:37 p.m., 34 minutes and 42 seconds - 4/15/25 at 12:21 p.m., 21 minutes and 39 seconds - 4/16/25 at 10:57 a.m., 18 minutes and 41 seconds - 4/16/25 at 12:20 p.m., 31 minutes and 20 seconds - 4/16/25 at 5:20 p.m., 24 minutes and 22 seconds - 4/16/25 at 7:32 p.m., 32 minutes and 38 seconds - 4/19/25 at 1:38 a.m., 26 minutes and 51 seconds - 4/20/25 at 11:12 a.m., 29 minutes and 16 seconds - 4/20/25 at 3:56 p.m., 23 minutes and 32	2 800		

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2 800	Continued From page 26 seconds - 4/20/25 at 7:41 p.m., 36 minutes and 34 seconds - 4/21/25 at 10:01 a.m., 36 minutes and 51 seconds - 4/22/25 at 12:28 p.m., 24 minutes and 18 seconds - 4/24/25 at 9:13 a.m., 265 minutes and 5 seconds - 4/24/25 at 1:40 p.m., 29 minutes and 14 seconds - 4/20/25 at 10:38 a.m., 22 minutes and 34 seconds - 5/3/25 at 10:52 a.m., 46 minutes and 44 seconds - 5/4/25 at 1:54 p.m., 53 minutes and 24 seconds - 5/5/25 at 6:09 p.m., 19 minutes and 12 seconds - 5/6/25 at 11:47 a.m., 24 minutes and 4 seconds - 5/6/25 at 5:39 p.m., 31 minutes and 19 seconds - 5/7/25 at 9:56 a.m., 22 minutes at 24 seconds - 5/7/25 at 5:56 p.m., 26 minutes and 44 seconds - 5/7/25 at 9:46 p.m., 49 minutes and 43 seconds - 5/10/25 at 8:06 a.m., 67 minutes and 58 seconds - 5/10/25 at 9:40 a.m., 21 minutes and 56 seconds - 5/10/25 at 5:27 p.m., 31 minutes and 21 seconds - 5/10/25 at 6:03 p.m., 21 minutes and 49 seconds - 5/11/25 at 10:22 a.m., 24 minutes and 52 seconds - 5/11/25 at 1:32 p.m., 30 minutes and 56 seconds - 5/12/25 at 7:56 p.m., 27 minutes and 33 seconds During an interview on 5/12/25 at 3:08 p.m., R1 stated things aren't going well. Staff would not answer the light. R1 had a bell that one of the	2 800		

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2 800	Continued From page 27 nurses gave him and directed R1 that if staff did not answer the call light in a reasonable time, to use the bell. R1 stated "I do scream" and staff would tell R1 to quit it. Staff would not answer the bell either, so R1 gave it away. R1 stated she would press her call light and wait so long that she turned it off because staff didn't answer. R1 stated she had fallen recently while trying to organize laundry in her room and staff told her to use her call light for assistance, but that was "a joke" because staff don't answer her light and have said they are shorthanded. R1 stated she used her call light when she needed to use the bathroom but staff don't answer, so "I end up going in my pull-ups" because she couldn't hold it for that long. R1 stated she felt helpless, and it sometimes took one or two hours for her call light to be answered. She stated, "I am bitter because I had to mess myself" because she could not get staff to come help her. On 5/12/25 at 5:18 p.m., a call light digital alarm board in the hallway displayed displayed "alarm [R1's room number] 15 minutes" and was flashing. NA-C entered R1's room. R1's call light log indicated her light was activated on 5/12/25 at 5:00 p.m. and was not cleared for 17 minutes and 58 seconds. Upon exiting, NA-C stated R1 wanted to go to the bathroom and usually if her call light is on it is because she wanted water or to go to the bathroom. NA-C stated she had taken R1 to the bathroom and cleaned her up after toileting. During an interview on 5/13/25 at 9:23 a.m., R1's friend and power of attorney (POA)-A stated R1 had called her crying before, stating she's uncomfortable, needed to get up, needed to go to the bathroom, and needed pain medication. POA-A told R1 to ring her bell while still on the	2 800		

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2 800	Continued From page 28 phone to see if staff come in and "she's ringing the bell, and nothing happens." POA-A stated this was not okay. R3 R3's MDS assessment dated 3/3/25, indicated she had intact cognition and no behaviors or rejections of care. R3 had diagnoses including stage four pressure ulcer of the sacral region (wound with full thickness tissue loss and exposed bone, tendon, or muscle over the tailbone area), low back pain, heart failure, non-Alzheimer's dementia, and depression. She was occasionally incontinent of bowel and bladder and required supervisory staff assistance with toileting hygiene and bathing, and partial assistance with footwear and walking. R3's urinary care plan included interventions dated 2/13/25, including keep call light within reach, staff to toilet every two to three hours and as needed with assist of one staff, and toilet per request. R3's routines care plan included intervention dated 2/13/25, directing "discuss with staff how to honor my preferences and provide care in a timely manner." R3's activities of daily living care plan included interventions dated 8/9/24, "I can verbally ask for assistance, I need assistance to help me remain free from skin breakdown and respect my dignity." Her pain care plan included a goal dated 5/3/25, to be comfortable. Intervention dated 9/5/24, noted interventions for pain included prescribed medications, relaxation, and distraction. R3's call light log dated 4/12/25 through 5/14/25, included the following reset times: - 4/12/25 at 5:20 p.m., 40 minutes and 21 seconds - 4/20/25 at 12:21 p.m., 26 minutes and 36	2 800		

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2 800	Continued From page 29 seconds - 4/21/25 at 12:11 p.m., 49 minutes and 11 seconds - 4/21/25 at 3:45 p.m., 36 minutes and 22 seconds - 4/26/25 at 8:53 a.m., 106 minutes and 54 seconds - 4/28/25 at 7:04 p.m., 44 minutes and 12 seconds - 4/30/25 at 8:41 a.m., 17 minutes and 2 seconds - 5/1/25 at 8:46 a.m., 51 minutes and 35 seconds - 5/4/25 at 12:21 p.m., 17 minutes and 43 seconds - 5/5/25 at 9:10 a.m., 124 minutes and 52 seconds - 5/5/25 at 12:52 p.m., 45 minutes and 40 seconds - 5/5/25 at 2:54 p.m., 33 minutes and 14 seconds - 5/7/25 at 7:36 a.m., 114 minutes and 47 seconds - 5/7/25 at 12:56 p.m., 32 minutes and 41 seconds - 5/8/25 at 1:15 p.m., 56 minutes and 11 seconds - 5/10/25 at 9:47 a.m., 105 minutes and 27 seconds - 5/10/25 at 6:34 p.m., 75 minutes at 14 seconds - 5/11/24 at 9:02 a.m., 119 minutes and 15 seconds - 5/13/25 at 11:01 a.m., 24 minutes 35 seconds - 5/14/25 at 8:38 p.m., 38 minutes and 14 seconds On 5/13/25 at 11:04 a.m., NA-A stated staffing was short sometimes, and they could use a little help. NA-A noted call lights should be answered in either eight to 10 minutes or five to eight minutes, she couldn't remember. NA-A noted she would usually turn call lights off right away and then go look for someone to help her if she was unable to provide the needed assistance. She	2 800		

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2 800	Continued From page 30 stated answering call lights can be a challenge and lights were usually on "for thirty minutes plus" which was pretty bad and a long time. NA-A noted she wouldn't like this if it was her family member. At 11:24 a.m., a call light digital alarm board in the hallway displayed "alarm [R3's room number] 20 minutes" and was flashing. NA-A entered R3's room and stated she was there because R3's call light was on and confirmed it had been on for 20 minutes. During an interview on 5/13/25 at 11:24 a.m., R3 stated it had "been a while" since she pressed her call light. R3 asked NA-A for as needed pain medication for back pain rated six out of 10. R3 thought nursing staff all went on break every hour because it sometimes took a long time for call lights to be answered. R3 noted call light wait times were not timely around mealtimes, as staff were busy preparing and serving meals and passing trays. R3 stated she realized staff were busy and she just had to be patient, but sometimes staff got mad and "then they ignore you." R6 R6's MDS assessment dated 2/18/25, indicated she had intact cognition and no behaviors or rejections of care. R6 had diagnoses including encephalopathy (disturbance in brain's function), sclerosis, anxiety, depression, and functional quadriplegia (complete inability to move all four limbs due to extreme debility or frailty). She was frequently incontinent of bowel and had an indwelling urinary catheter. R2 was dependent on staff for assistance with all cares, activities of daily living, and mobility. R6's mobility care plan dated 2/13/25, identified she needed assistance due to functional	2 800		

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2 800	Continued From page 31 quadriplegia. Intervention dated 5/7/26, directed "staff to ensure call light is in resident's reach while in room and encourage to use it to make needs known." R6's communication care plan dated 4/24/25, noted she used a specialized call light she accessed with her face/chin. R6's urinary care plan included interventions dated 2/13/25, including keep call light within reach, staff to toilet every two to three hours and as needed, and toilet per request. R6's call light log dated 4/12/25 through 5/14/25, included the following reset times: - 4/13/25 at 8:56 a.m., 58 minutes and 55 seconds - 4/18/25 at 2:38 p.m., 18 minutes and 4 seconds - 4/20/25 at 5:10 a.m., 28 minutes and 8 seconds - 4/20/25 at 7:04 a.m., 37 minutes and 0 seconds - 4/20/25 at 9:26 a.m., 30 minutes and 55 seconds - 4/20/25 at 11:00 a.m., 55 minutes and 37 seconds - 4/20/25 at 12:56 p.m., 51 minutes and 14 seconds - 4/21/25 at 9:20 a.m., 22 minutes and 45 seconds - 4/21/25 at 10:10 a.m., 43 minutes and 0 seconds - 4/21/25 at 1:31 p.m., 25 minutes and 3 seconds - 4/21/25 at 7:13 p.m., 23 minutes and 59 seconds - 4/22/25 at 5:22 a.m., 20 minutes and 4 seconds - 4/22/25 at 7:39 a.m., 30 minutes and 28 seconds - 4/22/25 at 9:16 a.m., 36 minutes and 43 seconds - 4/22/25 at 10:02 a.m., 20 minutes and 31 seconds - 4/24/25 at 11:22 a.m., 20 minutes and 36 seconds	2 800		

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2 800	Continued From page 32 - 4/24/25 at 5:01 p.m., 18 minutes and 47 seconds - 4/25/25 at 2:08 p.m., 19 minutes and 55 seconds - 4/25/25 at 2:35 p.m., 18 minutes and 50 seconds - 4/26/25 at 5:11 a.m., 60 minutes and 40 seconds - 4/26/25 at 6:41 a.m., 96 minutes and 29 seconds - 4/26/25 at 9:32 a.m., 55 minutes and 11 seconds - 4/26/25 at 10:54 a.m., 61 minutes and 9 seconds - 4/26/25 at 12:21 p.m., 34 minutes and 50 seconds - 4/26/25 at 2:26 p.m., 18 minutes and 4 seconds - 4/26/25 at 3:27 p.m., 31 minutes and 45 seconds - 4/27/25 at 2:34 p.m., 18 minutes and 50 seconds - 4/27/25 at 3:36 p.m., 36 minutes and 5 seconds - 4/27/25 at 5:30 p.m., 22 minutes and 24 seconds - 4/27/25 at 10:07 p.m., 50 minutes and 2 seconds - 4/28.25 at 5:25 a.m., 19 minutes and 3 seconds - 4/28/25 at 10:46 a.m., 48 minutes and 21 seconds - 4/29/25 at 7:50 a.m., 21 minutes and 13 seconds - 4/30/25 at 2:24 p.m., 23 minutes and 32 seconds - 5/1/25 at 10:56 a.m., 18 minutes and 32 seconds - 5/2/25 at 6:30 a.m., 28 minutes and 24 seconds - 5/2/25 at 7:09 a.m., 51 minutes and 11 seconds - 5/2/25 at 11:41 a.m., 36 minutes and 59 seconds - 5/4/25 at 5:40 a.m., 37 minutes and 11 seconds	2 800		

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2 800	Continued From page 33 - 5/4/25 at 12:08 p.m., 29 minutes and 32 seconds - 5/4/25 at 1:49 p.m., 27 minutes and 39 seconds - 5/4/25 at 1:18 p.m., 21 minutes and 34 seconds - 5/5/25 at 5:28 a.m., 29 minutes and 18 seconds - 5/5/25 at 8:37 a.m., 28 minutes and 18 seconds - 5/5/25 at 10:43 a.m., 20 minutes and 1 second - 5/5/25 at 1:49 p.m., 22 minutes and 15 seconds - 5/5/25 at 2:38 p.m., 54 minutes and 56 seconds - 5/5/25 at 6:58 p.m., 71 minutes and 0 seconds - 5/6/25 at 12:04 p.m., 26 minutes and 50 seconds - 5/7/25 at 4:17 p.m., 25 minutes and 59 seconds - 5/10/25 at 7:28 a.m., 45 minutes and 41 seconds - 5/10/25 at 9:53 a.m., 63 minutes and 46 seconds - 5/10/25 at 12:58 p.m., 106 minutes and 44 seconds - 5/10/25 at 2:46 p.m., 81 minutes and 29 seconds - 5/10/25 at 5:43 p.m., 72 minutes and 11 seconds - 5/10/25 at 7:26 p.m., 29 minutes and 53 seconds - 5/10/25 at 10:18 p.m., 32 minutes and 12 seconds - 5/11/25 at 3:47 a.m., 27 minutes and 26 seconds - 5/11/25 at 9:19 a.m., 92 minutes and 53 seconds - 5/11/25 at 7:13 p.m., 19 minutes and 51 seconds - 5/11/25 at 7:40 p.m., 20 minutes and 37 seconds - 5/11/25 at 10:00 p.m., 43 minutes and 56 seconds - 5/12/25 at 12:13 p.m., 36 minutes and 55 seconds - 5/12/25 at 3:23 p.m., 26 minutes and 10	2 800		

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2 800	Continued From page 34 seconds - 5/13/25 at 7:33 a.m., 44 minutes and 6 seconds - 5/14/25 at 9:32 a.m., 37 minutes and 47 seconds During an interview on 5/14/25 at 3:05 p.m., R6 stated she used her chin to press her specialized call light. R6 stated that when she used her call light staff sometimes came right away and sometimes "who knows" when they would come. R6 stated it pissed her off when staff didn't answer her call light in a timely manner and it "doesn't feel very good." She noted some staff would turn her call light off and leave without helping and she sometimes had to wait a really long time for assistance. R6 noted she had limited mobility and that's why she used the call light for staff assistance, such as when she wanted a sip of water. During an interview on 5/14/25 at 12:25 p.m., licensed practical nurse (LPN)-B stated everyone was responsible for answering call lights and they should be answered as soon as possible. LPN-B stated anything over 10 minutes was too long. When lights were not answered in a timely manner, LPN-B thought residents would feel ignored and might feel neglected. If it were her family member, she would feel "pretty upset." During an interview on 5/13/25 at 2:50 p.m., RN-B stated call lights are answered by everyone and if you can't provide the assistance needed, you should leave the call light on and get somebody who can help. RN-B stated she didn't know how quickly call lights should be answered, but maybe within half an hour. RN-B noted if staff were doing cares with another resident it would be "a little longer." RN-B stated staffing could be better and management had been having nurses	2 800		

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	00538	A. BUILDING: _____ B. WING _____	05/15/2025

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CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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2 800	Continued From page 35 leave early and come in late. She stated this didn't impact care as long as staff weren't busy but if multiple residents needed the nurse at the same time they didn't have the staff to get to them all quickly enough. RN-B thought more NA's were needed; when there were only two NA's or two with an extra floating between multiple units instead of three NA's, it was hard to answer call lights from 30-something residents. RN-B did not identify specific resident concerns with excessive call light response wait times. During an interview on 5/14/25 at 11:49 a.m., RN-C stated management sometimes had nurses leave early which made it "difficult" to get their work done. She recalled a recent instance where they were short one NA on the shift. RN-C stated call lights should be answered immediately and answering them after 15 minutes or half an hour was not okay. She stated call lights can be "tricky" and sometimes call lights would be on for a while when they should have been answered already. RN-C stated call lights were mostly answered on time and did not indicate awareness of resident concerns regarding excessive call light response wait times. During an interview on 5/14/25 at 5:22 p.m., the administrator stated nurse managers had been conducting call light audits. The administrator stated she hadn't heard of any concerns identified on the audits but had reviewed the call light logs requested by surveyors and they did not align with what was identified in the audits. During an interview on 5/15/25 at 3:39 p.m., the administrator stated call light times had not been identified as a continued issue through the audits, but they should have been. She noted call lights should be answered in less than 15 minutes and	2 800		

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2 800	Continued From page 36 15 minutes was too long. She confirmed a three-hour wait was too long, would make a resident feel "not good," and the mental and emotional impact of this would be not positive. During an interview on 5/15/25 at 8:15 a.m., the director of nursing (DON) stated everyone was responsible for answering call lights and they should be answered as soon as possible and identified her expectation as answering lights within 15 minutes, although sometimes that wasn't realistic. She noted call lights not being answered timely impacted residents because they had to wait longer for their needs to be met and this probably made them feel "not good." If a resident soiled themselves while waiting for a light to be answered they would feel "frustrated, worried, scared." If it took three hours for a light to be answered, the DON stated a resident wouldn't feel safe and noted call lights can be emergencies. The DON reviewed the call light audits completed by nurse managers and stated the call light times were not in line with her expectations and the data included in the audits identified ongoing concerns. Review of the facility Quality Assurance process identified past non compliancy with F725 citation for sufficient nursing staff related to call light times identified in a state agency survey with plan of correction dated 1/15/25. Facility Quality Council meeting PowerPoints and corresponding minute meeting notes for months of March and April 2025 indicated related audits were being completed. The Quality Council documentation identified data collection of resident concerns (grievances) and call light log audits. Documentation failed to include details of the audits completed or specifics of identified resident concerns. The Quality Assurance	2 800		

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2 800	Continued From page 37 process documentation failed to identify, investigate, analyze, or respond to ongoing current concerns with excessively long call light response wait times. Facility policy titled Call Lights - Call System Activation and Response dated 5/28/24, identified "The purpose of this procedure is to ensure timely responses to resident requests and needs. Residents are provided with a means to call for staff assistance through a communication system that directly notifies a staff member or a centralized work station." The policy included, "Each resident is provided with a means to call staff directly for assistance ... Calls for assistance may be triaged and answered as soon as possible based on immediate needs ... Call light response times are reviewed as part of the QAPI program." Facility policy titled Resident Rights and Notification of Resident Rights dated 1/16/24, included "The facility acts to protect and ensure the rights of residents." The policy noted resident right included responsive service, appropriate health care, respect and dignity, and accommodation of needs. The Facility Assessment dated 8/26/24, included a list of person-centered service and care offered based upon the needs of those the facility served. This list for bowel/bladder included "responding to requests for assistance to the bathroom/toilet promptly to maintain continence and promote resident dignity." The list for mental health and behavior included "identify and implement interventions to help support individuals with issues such as dealing with anxiety." The list for person-centered/directed care included "find out what resident's preferences and routines are;	2 800		

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2 800	Continued From page 38 what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process ... Support emotional and mental well-being." The Facility Assessment Follow Up section included areas identified by the facility assessment and action to be taken/already taken this year. Areas included staffing with action of agency reduction as well as QAPI initiatives/performance improvement projects with action of call light response time. SUGGESTED METHOD OF CORRECTION: The facility administrator or DON could review and revise policies and staffing schedules to assure adequate staff are available to assist residents in a timely manner to meet resident needs. The administrator or DON could educate all staff on the policies and procedures. The administrator or DON could conduct audits to ensure call lights are being answered promptly and the facility is staffed to ensure cares are being delivered timely, and report the findings of these audits to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon	2 945		6/17/25

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2 945	Continued From page 39 receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide adaptive eating utensils according to the care plan for 1 of 1 resident (R7) reviewed for nutrition. Findings include R7's face sheet dated 5/16/25, identified diagnosis of rheumatoid arthritis (a chronic inflammatory disorder affecting joints in hands or feet). R7's Minimum Data Set (MDS) dated 4/25/25, identified R7 was independent in eating and had intact cognition. R7's nutritional status focus care plan dated 5/7/25, identified a potential for altered nutrition related to rheumatoid arthritis, with an intervention of built-up utensils with all meals and culinary to provide.	2 945	Corrected	

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2 945	Continued From page 40 R7's nursing assistant care sheet dated 5/15/25, identified that R7 needed built-up utensils provided by the kitchen. R7's daily meal cards dated 5/15/25, identified R7 was to have built up utensils for all meals. R7's registered dietician progress note dated 3/6/25, identified R7 has continued to need built-up silverware to help with self-feeding related to rheumatoid arthritis. R7's grievance dated 3/21/25, identified R7 was not getting her built-up silverware with meals as ordered. An undated action identified culinary staff were educated on need to include built up silverware on meal tray. During an observation and interview on 5/15/25 at 12:54 p.m., R7 was in her room eating her meal of a pizza slice with a lettuce salad. R7 stated, "How am I supposed to eat my salad without my built-up silverware." R7 was supposed to get them with all her meals, however had not received them in a long time." R7 stated her right hand did not work very well due to her rheumatoid arthritis and she had difficulty holding onto a regular utensils. R7 explained without having built up silverware she just uses her fingers to eat her salad. During an interview on 5/15/25 at 1:27 p.m., licensed practical nurse (LPN)-C confirmed R7 did not receive built-up silverware for her noon meal and was supposed to be having them placed on her tray for each meal. LPN-C further stated the dietary department has been educated on making sure they are place; however, it continues to be a problem.	2 945		

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2 945	Continued From page 41 During an interview on 5/15/25 at 4:36 p.m., registered nurse regional director (RNRD) stated her expectation would be for dietary staff to follow the directions on the menu card and supply residents with the adaptive silverware if listed on the tray card for all meals. Review of the facility's Scope of Meal Service Policy undated, identified all culinary services personnel are responsible for the accuracy of tray assembly and all utensils are placed on the resident's tray. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on assistance with eating and the provision of special eating utensils. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure all residents in need of adaptive devices for dining and special eating utensils have such items provided and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to	21545		6/17/25

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21545	Continued From page 42 Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.	21545		

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21545	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and failed to identify and report medication errors for 2 of 3 (R1, R2) residents reviewed for medication administration. Findings include: R1 R1's Minimum Data Set (MDS) assessment dated 2/2/25, indicated she admitted to the facility on 10/29/24 with diagnoses including acute pain due to trauma and dorsalgia (pain in the upper back). R1 was on a scheduled pain medication regimen and received as needed (PRN) pain medications. R1's care plan revised 2/6/25, identified R1 experienced pain and discomfort. Interventions included administration of scheduled and PRN pain medication. R1's care plan also identified risk for alteration of skin status. Interventions included ensuring protective skin measures (barrier cream to dry areas and wheelchair cushion) were in place. R1's physician orders included an order for miconazole nitrate 2% topical cream (antifungal cream used to treat fungal or yeast infections) with start date 10/29/24 and discontinue date 5/15/25. Instructions were to apply to affected area topically twice daily scheduled for administration once between 7:00 a.m. and 3:00 p.m. (day) and again between 3:00 p.m. and 11:00 p.m. (evening). R1's physician orders included an order for	21545	Corrected	

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21545	Continued From page 44 tramadol oral tablet (an opioid pain medication used to treat moderate to moderately severe pain) 50 milligrams (mg) strength with start date 1/30/25. Instructions were to administer 25 mg orally four times a day for pain scheduled for administration at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R1's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled twice daily administrations of miconazole. Documentation of the miconazole as "not administered" included: - 3/1/25 day and evening doses with notes "drug/item unavailable" - 3/3/25 evening dose with comment "on order" - 3/6/25 evening dose with note "drug/item unavailable" - 3/7/25 day and evening doses with notes "drug/item unavailable" - 3/8/25 day dose with note "drug/item unavailable" - 3/15/25 day dose with note "drug/item unavailable" - 4/4/25 evening dose with note "drug/item unavailable" - 4/5/25 day and evening doses with notes "drug/item unavailable" - 4/6/25 day and evening doses with notes "drug/item unavailable" - 4/7/25 day dose with note "drug/item unavailable" - 4/24/25 evening dose with note "drug/item unavailable" - 4/25/25 day and evening doses with notes "drug/item unavailable" - 4/26/25 day and evening doses with notes "drug/item unavailable" - 5/2/25 day and evening doses with notes "drug/item unavailable"	21545		

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21545	Continued From page 45 - 5/4/25 day dose with note "drug/item unavailable" - 5/7/25 day dose with note "drug/item unavailable" R1's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled four daily administrations of tramadol. Documentation of the tramadol as "not administered" included: - 4/11/25 at 4:00 p.m. with note "drug/item unavailable" - 4/24/25 at 8:00 p.m. with note "med[ication] not here called pharmacy" - 4/25/25 at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. with notes "drug/item unavailable" - 4/26/25 at 8:00 a.m., 12:00 p.m., and 4:00 p.m. with notes "drug/item unavailable" R1's progress notes dated 4/24/25 at 6:45 p.m. and 6:55 p.m., indicated insurance would not cover the current dose of tramadol and wanted to change the dose. The pharmacy sent a fax to the facility to change the tramadol orders, R1 had no more tramadol available, and the on-call provider was notified. The on-call provider approved the pharmacy changing the tramadol order with new order for 50 mg tablets, give half tablet four times daily and once daily as needed for pain. Per pharmacy, insurance would cover this dose. Review of R1's progress notes did not identify further documentation regarding availability of the tramadol or miconazole, missed administrations, or related provider notifications. On 5/15/25 at 11:53 a.m., licensed practical nurse (LPN)-A stated on 4/24/25, R1 only had one remaining tramadol tablet. She contacted the pharmacy to re-order, was told R1's insurance	21545		

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21545	Continued From page 46 would no longer cover this tablet, and contacted the on-call provider for approval to change from 25 mg tablets to 50 mg tablets cut in half. LPN-A stated she notified the provider to get approval, but did not notify the provider of the missed dose at 8:00 p.m. when the medication was unavailable because she assumed the medication would arrive later that night after her shift ended. LPN-A stated if a medication was not administered, the physician should be notified and missed doses of medications without a provider order to hold were medication errors. LPN-A noted R1's miconazole had been discontinued earlier that morning because she did not use it and would say she didn't want it at times. LPN-A stated she would document medications as not administered with note that drug/item was unavailable when a medication was not available and would then call the pharmacy. LPN-A confirmed she was R1's nurse and in charge of the medication cart with R1's medications. During observation, LPN-A searched R1's medications in the cart, house stock medications in the cart, R1's room, and the medication room for R1's miconazole cream. LPN-A confirmed she had not removed it from the cart for disposal and was not able to locate the medication. LPN-A confirmed this was a physician ordered medication and should be available, thought noted there had been a lack of supply previously. During an interview on 5/15/25 at 8:15 a.m., the director of nursing (DON) stated medications should be available for administration as ordered. If a medication was not available, the provider should be notified. If a medication was not available and staff failed to obtain a provider order to hold (not give) the medication, it would be a medication error. The DON stated she was	21545		

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21545	Continued From page 47 not aware of R1's missed administrations of miconazole and tramadol. The DON stated if the tramadol was not given and the provider did not give an order to hold it, it would be considered a medication error. She stated she would expect R1's miconazole cream to be in stock and available for administration, would expect the provider to be notified if it was not, and would consider the missed administrations to be medication errors. The DON reviewed facility medication administration error reports and confirmed there were no medication errors reported for R1 between 3/1/25 and 5/13/25. During an interview on 5/15/25 at 10:46 a.m., the DON stated on 4/24/25 at 4:00 p.m. R1 received the last dose of her available tramadol, which was in 25 mg tablet form. On 4/24/25, staff were informed by the pharmacy that the 25 mg tablets would no longer be covered by insurance and got provider approval to change the prescription to half of a 50 mg tablet. R1 did not receive the medication again until 4/26/25 at 8:00 p.m. The DON stated she saw no indication the provider was notified of the ongoing lack of medication supply or missed administrations and would be processing this as a medication error. R2 R2's MDS dated 3/9/25, indicated he admitted to the facility on 12/3/24 with diagnoses including chronic obstructive pulmonary disease (COPD). R2's care plan revised 2/6/25, identified R2's goal of care was comfort focused. Interventions included medications, treatments, and cares as ordered by primary physician and nurse practitioner. R2's physician orders included an order for	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00538	A. BUILDING: _____ B. WING _____	05/15/2025

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21545	Continued From page 48 albuterol sulfate aerosol inhaler 90 micrograms (mcg) per actuation with start date 12/3/24. Instructions were to inhale two puffs four times a day for COPD scheduled for administration at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. R2's provider visit note dated 5/13/25, indicated he had a history of COPD with previous hospitalizations for pneumonia and COPD exacerbation. The note indicated R2's COPD was managed with medications including two puffs of an albuterol inhaler four times a day. R2's medication administration record (MAR) dated 3/1/25 through 5/13/25, included the scheduled four daily administrations of albuterol. Documentation of the albuterol as "not administered" included: 4/2/25 at 4:00 p.m. and 8:00 p.m. with note "drug/item unavailable" Review of R2's progress notes did not identify documentation regarding availability of the albuterol inhaler, missed administrations, or related provider notifications. During an interview on 5/15/25 at 2:20 p.m., the DON confirmed documentation reflected two missed doses of albuterol on 4/2/25 with notes that it was unavailable. The DON stated she was not informed of this and did not see it in the facility's medication error reports. The DON stated she would expect it to be identified as a medication error and to be reported to the provider. The DON noted the medication was not administered in accordance with physician orders. Facility policy titled Administering Medications dated 8/31/23, included "2.) Medications are administered in accordance with the orders. 3.)	21545		

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21545	Continued From page 49 Medications are administered within their prescribed time. 4.) The person preparing or administering the medication will contact the provider if there are questions or concerns regarding medication. 5.) With any irregularities, appropriate notifications will be completed for clarification." Facility policy titled Medication Error/Occurrence dated 8/31/23, included definition of a medication error as "the preparation or administration of drugs or biologicals which is not in accordance with the attending providers' orders, manufacturer's specification or accepted standards and principles of the professional providing the services." Examples of medication errors included "omissions." The policy included "When an error is made in the preparation or administration of a drug or biological, the licensed nurse provides any necessary immediate care and notifies the attending provider and resident or resident representative when nursing or medical intervention, observation or treatment is indicated. Medication errors are tracked and trended for quality improvement purposes ... Insignificant medication errors such as a missed vitamin C will be internally investigated and may not be reported as nursing or medical treatment is not necessary. Frequent nonsignificant errors will require additional process investigation and performance improvement interventions including notification to the medical director. The licensed nurse and/or nurse supervisor may notify the attending physician and resident/resident representative of medication errors as deemed appropriate ... Documentation includes the date, time of the error or discovery of error, the resident's condition, including vital signs, notification of provider, medical orders and notification of the resident/resident	21545		

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21545	Continued From page 50 representative." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on medication administration and medication errors. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure all staff members are administering medications in accordance with physician orders and correctly identifying and reporting medication errors and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		