Electronically delivered
August 5, 2021

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

RE: CCN: 245365
Cycle Start Date: June 8, 2021

Dear Administrator:

On July 1, 2021, we notified you a remedy was imposed. On July 20, 2021 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 July 15, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 16, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 1, 2021, 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 July 16, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 15, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

August 5, 2021

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

Re: Reinspection Results
Event ID: R47P12

Dear Administrator:

On July 20, 2021 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 June 8, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
July 1, 2021

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

RE: CCN: 245365
Cycle Start Date: June 8, 2021

Dear Administrator:

On June 8, 2021, 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), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 16, 2021.

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.

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 $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 16, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cerenity - Marian Of St Paul LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 16, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 December 8, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	C 06/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/3/21, through 6/8/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5365045C (MN73407; MN73192), with deficiencies cited at F580, F684. 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		7/15/21

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

Electronically Signed | 07/09/2021

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 580	This plan of correction is not an	

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F 580	Continued From page 2 review, the failed to notify the provider of labile (tendency to change from really high to really low blood pressure) and abnormal blood pressure readings for 2 or 4 residents (R1, R4) reviewed for notification of change. Findings include: R4's Face Sheet printed 6/8/21, indicated hypertensive chronic kidney disease (elevated blood pressure caused by kidney disease) with stage 1 through stage 4 chronic kidney disease (indicates advanced kidney damage), arteriosclerotic heart disease of native coronary artery (blockage in the artery of the heart that can cause heart attacks) without angina pectoris (severe pain in the chest, often also spreads to the arms and neck) and orthostatic hypotension (systolic blood pressure decrease of at least 20 millimeter of mercury (mm hg which is a manometric unit of pressure) or a diastolic blood pressure decrease of at least 10 mm Hg within three minutes of standing. R4's admission Minimum Data Set dated 4/14/21, indicated R4 had severe cognitive impairment with diagnoses that included atrial fibrillation (an irregular and often rapid heart rate) or other dysrhythmias (abnormal heart rhythms), coronary artery disease (develops when the major blood vessels that supply your heart become damaged or diseased) and hypertension (high blood pressures). R4's care plan updated 4/27/21, indicated R4 had elevated systolic blood pressure readings with diagnosis of hypertension, with the goal to maintain systolic blood pressure reading under 160 mm hg. Interventions included vitals and	F 580	admission of guilt on behalf of the provider. This plan of correction is being submitted because it is required by law. Resident #1 is no longer residing at the facility. Resident #4□s BP□s are monitored per the plan of care and abnormal results are communicated to the NP/MD based on the individualized parameters set. Residents□ BP□s are monitored per MD/NP orders or their individualized plan of care. Abnormal BP□s obtained from the vital signs machines are re-checked with a manual cuff per policy. NP/MD will be updated on abnormal BP readings per facility policy. Parameters for BP readings have been established for guidance to staff on contacting the NP/MD. Staff have been re-educated on the facility□s policy regarding obtaining BPs and NP/MD notification. Education began on 7/8/2021 and will continue until all nursing staff have been re-educated. The DON, or her designee, will audit all abnormal BP readings 5Xs per week for 4, then 3Xs per week for 2 weeks, and then 1 time per week for 2 weeks to ensure NP/MD notification. Issues identified will be referred to the facility□s QAPI Team for input/suggestions from the Team. The DON is responsible for ensuring that abnormal BPs requiring MD/NP notification are reported to the providers.	

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F 580	Continued From page 3	F 580		

weights per medical doctor (MD) orders and house standing orders and update MD as needed.

R4's Physician Orders Report dated 4/8/21, indicated amlodipine (medication used to treat high blood pressure) 5 milligrams (mg), give one (5 mg) tablet orally at bedtime at 8:00 p.m.

R4's Physician Orders Report dated 6/4/21, indicated amlodipine 5 mg tablet, give 10 mg orally at bedtime at 8:00 p.m.

R4's Blood Pressure Vital Results dated 4/8/21, to 6/4/21, included the following abnormal elevated blood pressure results:
- 4/8/21, 212/96 at 6:14 p.m.
- 4/8/21, 190/82 at 9:16 p.m.
- 4/9/21, 178/78 at 1:22 a.m.
- 4/9/21, 170/71 at 6:07 a.m.
- 4/10/21, 178/80 at 4:50 a.m.
- 4/10/21, 170/81 at 10:01 p.m.
- 4/11/21, 176/75 at 04:36 a.m.
- 4/13/21, 171/79 at 6:03 p.m.
- 4/14/21, 180/76 at 5:08 p.m.
- 4/15/21, 171/72 at 5:27 p.m.
- 4/16/21, 160/72 at 5:30 a.m.
- 4/17/21, 184/79 at 4:25 a.m.
- 4/25/21, 165/60 at 03:47 a.m.
- 5/8/21, 190/79 at 5:16 p.m.
- 5/8/21: 171/85 at 9:57 p.m.
- 5/22/21: 170/75 at 6:00 p.m.

R4's Blood Pressure Vital Results dated 4/8/21, to 6/4/21, lacked documentation that blood pressures had been rechecked after elevated abnormal blood pressure results were taken or and lacked evidence the provider had been updated.

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F 580	Continued From page 4	F 580		

During interview on 6/7/21, at 1:02 p.m. nurse practitioner (NP)-A stated she typically read progress notes when she completed routine visits and had not seen any mention in the progress notes about the urethral erosion prior to 5/5/21, by the facility staff. NP-A further stated R4 was admitted 4/21, and she saw each resident at least once a month and was also on campus at the facility at least three times per week. NP-A stated the facility staff had access to contact the provider when not onsite, 24 hours per day. NP-A stated she had communicated to facility nurses and managers her expectation of notifying providers with changes in resident condition. NP-A also stated the facility had not updated providers when blood pressure readings were abnormal.

During interview on 6/7/21, at 2:15 p.m. R4's primary medical doctor (MD)-A indicated it was expected when residents had high blood pressure that the facility staff completed a neurological assessment to determine the presence of headaches. MD-A explained facility staff were to intervene by having resident lay down and recheck blood pressure using a manual blood pressure machine as this was more accurate than the electronic blood pressure machine. MD-A also stated if a resident had high blood pressure readings facility staff had a policy regarding the range of BP that required notification to the provider. It was the expectation that residents with ongoing high blood pressures were assessed with a high blood pressures and providers were notified even when a resident was asymptomatic.

During interview on 6/8/21, at 11:15 a.m. trained

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medical aide (TMA)-A stated nurses completed routine vitals including blood pressure checks; however, when the nurse was busy the TMA's and nursing assistants (NA)'s would do the vitals and they notified the nurse immediately when the readings were abnormal. TMA-A also stated the electronic medical record (EMAR) flagged after results were entered and alerted staff that the vitals readings were out of normal range.

During interview on 6/8/21, at 11:54 a.m. nurse manager RN-G stated the expectation was that staff notified the provider immediately with abnormal vitals signs including the elevated abnormal blood pressure results. RN-B further indicated that with R4's elevated systolic blood pressure above 160's mm hg, the nursing staff should have updated the provider immediately and the provider would have been the one to make the determination on how to proceed with the elevated results. RN-B verified facility staff did not document that R4's blood pressures were rechecked when elevated and R4's documents also lacked evidence that the provider was updated when R4's systolic blood pressures where elevated.

During interview on 6/8/21, at 1:51 p.m. the director of nursing (DON) stated when a resident was noted to have elevated abnormal blood pressure, the facility staff were expected to recheck the "old fashion" way and use the manual blood pressure cuff as sometimes the electronic blood pressure machine could read erroneous results. The DON stated if blood pressure readings were consistently high, and the provider was not going to be in house, staff needed to call the provider. The DON further stated the EMAR flagged abnormal vitals results

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F 580	Continued From page 6	F 580		

and alerted staff of the abnormal range.

Documentation that indicated the facility had updated the provider with elevated blood pressures for R4, and that elevated abnormally high blood pressure levels were rechecked immediately was requested and not provided.
R1's admission Minimum Data Set (MDS) identified R1 had a brief interview for mental status (BIMS) of 14 out of 15, indicated R1 was cognitively intact. R1 required extensive assistance with bed mobility, transfers, dressing, and toileting.

R1's Facesheet undated, indicated diagnoses that included hypertension (high blood pressure), congestive heart failure, orthostatic hypotension (drop in blood pressure with change in positioning), hypertensive urgency, renal insufficiency (poor kidney function), sepsis relating to a urinary tract infection, and Parkinson's disease.

R1's care plan dated 5/6/21, indicated R1 had high blood pressure (BP) readings and exhibited large drops in BP related to medications given to treat hypertension (HTN). A goal dated 5/6/21, identified R1's systolic BP would remain between 150 millimeters of mercury (mmHg) and 90 mmHg. Interventions included observation for signs and symptoms including fatigue and increased BP. Staff was instructed to assess vital signs and update the provider as needed.

R1's Physician Orders Report, undated, indicated R1 received three medications to treat high blood presure: clonidine HCl, hydralazine and losartain.

R1's Blood Pressure Vital Results dated 4/24/21,

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F 580	Continued From page 7	F 580		

to 5/31/21, contained the following BP readings which lacked documentation of provider notification:

- 4/24/21, 194/89 at 7:45 a.m.
- 4/30/21, 187/87 at 9:25 p.m.
- 5/1/21, 193/95 at 4:20 a.m.
- 5/2/21, 191/85 at 9:21 a.m.
- 5/4/21, 180/77 at 7:22 a.m.
- 5/4/21, 69/40 at 1:09 p.m.
- 5/9/21, 183/80 at 7:22 a.m.
- 5/9/21, 188/84 at 8:47 p.m.
- 5/9/21, 190/82 at 10:39 p.m.
- 5/20/21, 180/91 at 9:10 p.m.
- 5/21/21, 190/97 at 9:09 a.m.
- 5/21/21, 208/88 at 8:52 p.m.
- 5/22/21, 199/74 at 8:32 p.m.
- 5/23/21, 182/84 at 7:19 a.m.
- 5/25/21, 180/81 at 11:39 p.m.
- 5/27/21,182/75 at 8:13 a.m.
- 5/27/21, 58/38 at 11:43 a.m.
- 5/29/21, 193/98 at 2:26 a.m.
- 5/31/21, 197/92 at 8:34 p.m.

When interviewed on 6/4/21, at 10:16 a.m. licensed practical nurse (LPN)-A stated if a resident's vital signs were abnormal she would call the nurse practitioner (NP)-A triage office to update the provider.

When interviewed on 6/4/21, at 1:00 p.m. NP-A described R1 as having labile BPs (readings which ranged from very high to very low). NP-A stated she reviewed R1's progress notes and BP history and noted staff were inconsistent in providing updates. She stated if systolic BP was below 100 or above 180 she expected staff would have notified her as interventions may have been required. She stated she had discussed this with

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a nurse manager and many bedside nurses, and staff were aware of the expectations relating to house standing orders.

When interview on 6/4/21, at 2:04 p.m. registered nurse (RN)-A stated if a resident's BP was abnormal she would recheck it, give water, and given PRN medications if ordered. She would recheck the resident in 30 minutes to one hour.

When interviewed on 6/4/21, at 2:16 p.m. nursing assistant (NA)-A stated R1's BP fluctuated often. When R1's BP was low she became fatigued and NA-A placed R1 in bed, elevated R1's feet until she was stable, and informed the nurse.

When interviewed on 6/4/21, at 2:42 p.m. NA-B stated when she obtained a low BP reading she would obtain a second BP, asked the resident what their normal BP was, encouraged water, and reported to the nurse.

When interviewed on 6/6/21, at 3:29 p.m. RN-B stated she expected the NAs to tell her if they obtained abnormal BP readings. She stated there were standing house orders which instructed staff to notify a provider if a systolic BP was above 140 or below 60. She treated the resident's BP with PRN (as needed) medications if ordered, rechecked the BP one hour later, and updated the NP.

When interviewed on 6/6/21, at 3:40 p.m. RN-C stated if an NA reported an abnormal BP for a resident she checked them again herself. If BP was still not within normal range she assessed the resident, gave a PRN medication if ordered, and notified the provider regardless of the efficacy of the given medication. She stated if a

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resident had a systolic BP of 170 or higher she would definitely call the provider, monitor the resident, and document a note in the record.

When interviewed on 6/6/21, at 3:54 p.m. RN-D stated if BP readings were abnormal staff took them again. If they were still abnormal staff were expected to tell the nurse who would check them manually. If they were still abnormal RN-D expected staff to notify the provider. RN-D reviewed progress notes for R1 and was unable to locate documentation of provider notification for each instance of abnormal BP readings.

When interviewed on 6/7/21, at 2:01 p.m. R1's physician (MD)-A stated if a resident had a high BP he would expect staff to perform a manual BP check and assess the resident. He stated he expected to be notified if the resident's BP was below 70 systolic, above 160 systolic with symptoms, or above 180 regardless of the presence of symptoms. He also stated that they [facility staff] were supposed to document provider notification.

The facility Standing House Order policy was requested and not provided.

The facility Change in Condition policy undated, directed staff to assess significant change in the resident's condition noted through direct observation, interview or report from the other staff. Facility staff were to notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If staff were unable to contact the physician, they were to contact the Medical Director as appropriate. The community was to immediately inform the resident, consults

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F 580	Continued From page 10 with the resident representative when there was significant change in the resident's physical, mental or psychosocial status, or when there was the need to alter treatment significantly.	F 580		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure indwelling catheter management and skin assessments were completed to prevent erosion (tearing) of the penile urethral (opening for urine to pass out of body) for 1 of 3 resident (R4), whom had an indwelling urinary catheter. This caused actual harm for R4. Findings include: R4's Face Sheet printed 6/8/21, indicated diagnoses that included neuromuscular dysfunction of bladder (a condition that results in loss of control of the bladder), unspecified obstructive and reflux uropathy (the obstruction of urine flow to the bladder from the kidneys and the flow of urine flowing backward into the kidneys), benign prostatic hyperplasia (enlarged prostate gland) with urinary tract symptoms, chronic	F 684	Resident #4 had a suprapubic catheter inserted on 6/8/2021. Resident #4□s skin continues to be monitored per facility policy. A list of residents with an indwelling or suprapubic catheter has been developed. These residents are provided daily catheter care and weekly skin assessments to prevent genital irritation. Staff were re-educated on catheter care and management on 7/8/2021 and education will continue until all nursing staff have been re-educated. Education included skin monitoring to prevent skin breakdown. The DON, or her designee, will perform 3 audits on each resident with a catheter for 4 weeks, 2 audits on each resident with a catheter for 4 weeks, and then 1 audit each week on each resident with a	7/15/21

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F 684	Continued From page 11 kidney disease stage 3 (when the kidneys are not working well, causing swelling in hands and feet, back pain, and urinating more or less than normal). R4's admission Minimum Data Set dated 4/14/21, indicated R4 was admitted in 4/21, had severe cognitive impairment, required extensive assist of two staff for toileting, bed mobility and transfers with Care Area Assessment triggered for urinary incontinence and indwelling catheter. R4's care plan dated 4/9/21, indicated R4 required an indwelling urinary catheter (a tube that goes into the bladder to empty it and remains in place) related to neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), with urinary retention and interventions included use of a catheter strap (used to keep indwelling urinary catheter secured), and to document urinary output every shift. Staff were to change the indwelling urinary catheter monthly and as needed (PRN). Staff were also to record the amount, type, color, odor and observe for leakage. R4's care plan dated 4/9/21, lacked documentation for monitoring R4's skin for irritation with the use of the indwelling urinary catheter. R4's Physician Orders Report dated 4/8/21, indicated to record indwelling urinary catheter output every shift; to change the indwelling urinary catheter every four weeks; and to use a leg bag when up and night drainage bag when in bed. R4's Admission Body Audit: Skin Condition dated	F 684	catheter for 4 weeks. Issues identified with catheter care and skin assessment will be forwarded to the facility'□s QAPI Team for input/suggestions from the Team. The DON is responsible for ensuring that daily catheter care and weekly skin assessments are completed per facility policy.	

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4/8/21, lacked assessment of any penile skin irritation.

R4's Admission Body Audit: Skin Condition dated 4/15/21, lacked assessment of any penile skin irritation.

R4's Skin Risk Assessment with Braden Scale dated 4/27/21, lacked assessment of any penile skin irritation.

R4's Progress notes dated 5/2/21, at 2:11 p.m. indicated R4's indwelling urinary catheter replaced, 16 French (Fr) 10 cubic centimeters (cc) balloon with light yellow urine return. Resident tolerated insertion with some discomfort but stated he was alright once catheter was in place. Declined pain medication. There was no mention of any penile skin irritation or erosion.

R4's Skin Risk Assessment with Braden Scale dated 5/3/21, lacked assessment of any penile skin irritation.

R4's progress notes dated 5/5/21, at 12:50 p.m. indicated updated nurse practitioner (NP) on appearance of meatus (a passage or opening leading to the interior of the body) and glans penis (tip of the penis). Order received for urology referral for indwelling urinary catheter erosion concerns and evaluation for placement of supra-pubic catheter.

R4's NP progress notes dated 5/5/21, printed at 9:40 p.m. indicated: nursing staff also expressed concerns with the indwelling urinary catheter . They reported that part of the catheter could be seen farther down on his penis. There was concern for further opening or erosion around the

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insertion site of the indwelling urinary catheter. The note further indicated R4 was seen in his wheelchair on 5/5/21, and the NP was unable to examine his private areas. NP discussed with staff and was going to refer to urology for evaluation.

R4's physician orders dated 5/5/21, indicated schedule appointment with urology for indwelling urinary catheter erosion concerns and evaluation for supra-pubic catheter (SP-catheter inserted into the bladder via the anterior abdominal wall).

R4's physician orders dated 5/17/21, indicated appointment on Tuesday 5/25/21, at 12:50 p.m. at a urology clinic.

R4's progress notes dated 5/25/21, indicated R4 returned from urology appointment with new orders for placement of a suprapubic (SP) catheter with follow up appointment with urology in a month.

R4's physician orders dated 5/27/21, indicated an appointment on Thursday 6/3/21, at 12:00 p.m. for a SP catheter placement at a local hospital

R4's physician orders dated 6/8/21, indicated R4 must be "nothing by mouth" (NPO) after 5:00 a.m. on Tuesday 6/8/21 due to SP catheter placement.

Notes from R4's urology appointments were requested and not provided by the facility. Several attempts were made to interview the urologist were unsuccessful .

During an observation on 6/4/21, at 11:20 a.m. R4 was in dining room sitting at a table with his indwelling urinary catheter drainage leg bag

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visible below his left pants leg. R4's foley catheter straps were hanging loose around his left ankle and not securing the tubing to his leg causing pulling/pressure of the catheter on his penile urethral meatus.

During an observation on 6/7/21, at 3:31 p.m. registered nurse (RN)-B and nursing assistant (NA)-A entered R4's room to assist with getting R4 out of bed and into his wheelchair. RN-B lifted R4's penis and explained that the split under the penis was the erosion and R4 had some reddened irritation. R4 had an approximate one-to-two-inch split under his penis from his urethral down the meatus downward at the base of his penis. The catheter was visible inside the split area entering the urethral duct (transmits urine from the bladder to the exterior of the body during urination).

During an observation on 6/8/21, at 9:25 a.m. R4 was in bed lying on his left side. R4's catheter drain bag was within the privacy pouch attached onto R4's bed frame. R4's lower indwelling urinary catheter leg strap was not attached to resident but was on the catheter tubing line, near the drainage bag. The second leg strap for the indwelling urinary catheter tubing was unattached to R4's body but under R4's left ankle area. The lack of a securely placed leg strap could result in pulling of the indwelling urinary catheter causing more pull on the urethra and could have further worsened any penile skin irritation or erosion.

During interview on 6/7/21, at 1:02 p.m. nurse practitioner (NP)-A stated R4 had penile urethral erosion at the base of his penis was caused from catheter use and she was unaware of this until the facility staff notified her on 5/5/21. NP-A

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stated that she had been unable to visually assess R4's perineal area or catheter insertion site/penis as R4 was usually up in his wheelchair (W/C) or was asleep during rounds. NP-A stated she typically read progress notes when she completed routine visits and had not seen any mention in the progress notes about the urethral erosion prior to 5/5/21 by the facility staff. NP-A further stated R4 was admitted 4/8/21, and she saw each resident at least once a month but was on campus at the facility at least three times per week. NP-A stated the facility staff had access to contact the provider when not onsite, 24 hours per day. NP-A stated she had communicated to facility nurses and managers her expectation of notifying providers with change in condition in residents. NP-A stated an order for urology consult was placed on 5/5/21, after staff had updated her on R4's penile urethral erosion. NP-A stated had the facility assessed and monitored R4's catheter insertion site and updated NP-A timely of the penile urethral erosion, the penile urethral erosion may have been avoidable.

During interview on 6/7/21, at 2:45 p.m. licensed practical nurse (LPN)-C stated she had changed R4's foley catheter on 5/2/21, and noted the penile urethral erosion. LPN-C stated she thought she had updated the NP but was unable to find the documentation. LPN-C stated, on 5/5/21, she documented she had informed the NP of the penile urethral erosion and had received referral orders for urology consult.

During interview on 6/7/21, at 3:45 p.m. RN-B stated R4 was noted to have the penile urethral erosion when RN-B worked with R4 during peri cares, a few days after his admission. RN-B stated R4's penis definitely looked different and

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was unusual with the erosion beginning at the meatus into the base of R4's penis and it looked irritated. RN-B further stated she could not recall if she had charted on the penile urethral erosion and had assumed it was at baseline for the R4, since R4 had urology issues in the past and that there was no active bleeding. RN-B indicated she had verbally informed the night shift about the penile urethral erosion but was unable to remember who the night nurse was. RN-B also stated several nursing assistants had come and verbalized their concerns about the catheter to her on different days. RN-B also stated in retrospect she should have notified the nurse manager and the provider about the penile urethral erosion immediately and should have also updated the nursing assistant care sheets on cleaning the site properly. RN-B verified that she had not updated the provider and did not document in R4's progress notes or skin assessments concerning the penile urethral erosion.

During interview on 6/7/21, at 4:28 p.m. family member (FM)-A stated he had not been updated regarding any issues with R4's penile urethral erosion, until sometime in May 2021 when he was informed that R4 was to be seen by a urologist due to penile urethral erosion. FM-A also stated the previous facility had not mentioned any issues with R4's prior to his discharge. Initially R4 went to the urologist while at a previous facility; but due to COVID-19, the nurses had been changing the catheter onsite while at the previous facility. FM-A stated, R4 had not had any concerns about erosions communicated to him by the previous facility prior to discharge.

During interview on 6/7/21, at 4:40 p.m. FM-B

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stated she had come to visit R4 while residing at current facility and observed catheter straps (which prevented pulling of the foley catheter from the urethra) were not in place and the catheter tubing looked dirty.

During telephone interview on 6/8/21, at 8:57 a.m. LPN-D, who worked at the facility where R4 previously resided, stated when R4 was discharged from the previous facility he had no skin issues with his foley catheter. LPN-D stated if resident had any skin conditions it would have been documented and stated R4 had no openings with his penis while at their facility. LPN-D also verified that she had changed R4's catheter several times and noted no skin issues or abnormalities. LPN-D further stated R4's catheter was last changed on 4/5/21, at the previous facility and there was no indication of skin issues that were identified in the documents.

During interview on 6/8/21, at 11:15 a.m. trained medication aide (TMA)-A stated she had worked with R4 within several days after his admission to the facility and observed his penis was split at the bottom and looked different. TMA-A stated she immediately verbally informed the nurse on duty, and further stated only the nurses completed the skin assessments.

During interview on 6/8/21, at 11:54 p.m. unit manager (RN)-G stated she had called the previous facility R4 resided at and was informed by the staff at previous facility that R4 did not have any skin concerns with his foley catheter. RN-G stated there was no indication on the current facility's admission skin assessment that identified penile urethral erosion. RN-G also verified the nursing progress notes and skin

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assessments from admission on 4/8/21 through 5/4/21, lacked documentation of R4's penile urethral irritation or erosion.

During interview on 6/8/21, at 1:51 p.m. the director of nursing (DON) stated she was informed that R4 possibly had the penile urethral erosion upon admission; however, there was no documentation to show this was present on admission. DON stated it was the expectation that the admitting nurse did a thorough skin assessment and documented findings of abnormal skin conditions in the resident's chart. It was also the expectation that staff informed other nursing staff if a resident had a penile urethral erosion for continued monitoring and to also immediately notify the provider with this assessment finding.

The facility Prevention of Catheter-Associated Urinary Tract Infections Policy updated 12/29/17 indicated when a resident was admitted to the facility with a catheter in place, a thorough physical assessment as well as history review was to be completed. Catheter were to be Secured to avoid pulling and trauma to the bladder and urethra. The peri-urethra was cleaned regularly with mild soap and water and then rinsed. Staff were to always wash from the area of least contamination to the area of greatest and wipe from front to the back.

The facility Resident Examination and Assessment Policy undated, indicated a through resident examination and assessment was to capture any abnormalities in health status, physical function, or an acute change in condition. This assessment was to provide the basis for the initial care plan, as well as provide additional

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F 684	Continued From page 19 updates to care plan as indicated. Physical exam and or refusals were to be documented in the Electronic Health Record. The facility Prevention and Treatment of Skin Breakdown Policy undated indicated skin integrity is monitored, and abnormal findings were to be documented. Skin was to be observed daily with cares. If any skin concerns were noted, they were to be reported to the licensed nurse. Weekly skin audits were to be performed by a licensed nurse.	F 684		

Electronically delivered
July 1, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: R47P11

Dear Administrator:

The above facility was surveyed on June 3, 2021 through June 8, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00354	A. BUILDING: _____ B. WING _____	C 06/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 6/3/21, through 6/8/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5365045C (MN73407; MN73192) with licensing orders issued at 0265 and 0830. 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 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	2 000		

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2 000	Continued From page 2 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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		7/15/21

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the failed to notify the provider of labile (tendency to change from really high to really low blood pressure) and abnormal blood pressure readings for 2 or 4 residents (R1, R4) reviewed for notification of change. Findings include: R4's Face Sheet printed 6/8/21, indicated hypertensive chronic kidney disease (elevated blood pressure caused by kidney disease) with stage 1 through stage 4 chronic kidney disease (indicates advanced kidney damage), arteriosclerotic heart disease of native coronary artery (blockage in the artery of the heart that can cause heart attacks) without angina pectoris (severe pain in the chest, often also spreads to the arms and neck) and orthostatic hypotension (systolic blood pressure decrease of at least 20 millimeter of mercury (mm hg which is a manometric unit of pressure) or a diastolic blood pressure decrease of at least 10 mm Hg within three minutes of standing. R4's admission Minimum Data Set dated 4/14/21, indicated R4 had severe cognitive impairment with diagnoses that included atrial fibrillation (an irregular and often rapid heart rate) or other dysrhythmias (abnormal heart rhythms), coronary artery disease (develops when the major blood vessels that supply your heart become damaged	2 265	Corrected	

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2 265	Continued From page 4 or diseased) and hypertension (high blood pressures). R4's care plan updated 4/27/21, indicated R4 had elevated systolic blood pressure readings with diagnosis of hypertension, with the goal to maintain systolic blood pressure reading under 160 mm hg. Interventions included vitals and weights per medical doctor (MD) orders and house standing orders and update MD as needed. R4's Physician Orders Report dated 4/8/21, indicated amlodipine (medication used to treat high blood pressure) 5 milligrams (mg), give one (5 mg) tablet orally at bedtime at 8:00 p.m. R4's Physician Orders Report dated 6/4/21, indicated amlodipine 5 mg tablet, give 10 mg orally at bedtime at 8:00 p.m. R4's Blood Pressure Vital Results dated 4/8/21, to 6/4/21, included the following abnormal elevated blood pressure results: - 4/8/21, 212/96 at 6:14 p.m. - 4/8/21, 190/82 at 9:16 p.m. - 4/9/21, 178/78 at 1:22 a.m. - 4/9/21, 170/71 at 6:07 a.m. - 4/10/21, 178/80 at 4:50 a.m. - 4/10/21, 170/81 at 10:01 p.m. - 4/11/21, 176/75 at 04:36 a.m. - 4/13/21, 171/79 at 6:03 p.m. - 4/14/21, 180/76 at 5:08 p.m. - 4/15/21, 171/72 at 5:27 p.m. - 4/16/21, 160/72 at 5:30 a.m. - 4/17/21, 184/79 at 4:25 a.m. - 4/25/21, 165/60 at 03:47 a.m. - 5/8/21, 190/79 at 5:16 p.m. - 5/8/21: 171/85 at 9:57 p.m. - 5/22/21: 170/75 at 6:00 p.m.	2 265		

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2 265	Continued From page 5	2 265		

R4's Blood Pressure Vital Results dated 4/8/21, to 6/4/21, lacked documentation that blood pressures had been rechecked after elevated abnormal blood pressure results were taken or and lacked evidence the provider had been updated.

During interview on 6/7/21, at 1:02 p.m. nurse practitioner (NP)-A stated she typically read progress notes when she completed routine visits and had not seen any mention in the progress notes about the urethral erosion prior to 5/5/21, by the facility staff. NP-A further stated R4 was admitted 4/21, and she saw each resident at least once a month and was also on campus at the facility at least three times per week. NP-A stated the facility staff had access to contact the provider when not onsite, 24 hours per day. NP-A stated she had communicated to facility nurses and managers her expectation of notifying providers with changes in resident condition. NP-A also stated the facility had not updated providers when blood pressure readings were abnormal.

During interview on 6/7/21, at 2:15 p.m. R4's primary medical doctor (MD)-A indicated it was expected when residents had high blood pressure that the facility staff completed a neurological assessment to determine the presence of headaches. MD-A explained facility staff were to intervene by having resident lay down and recheck blood pressure using a manual blood pressure machine as this was more accurate than the electronic blood pressure machine. MD-A also stated if a resident had high blood pressure readings facility staff had a policy regarding the range of BP that required notification to the provider. It was the expectation

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2 265	Continued From page 6	2 265		

that residents with ongoing high blood pressures were assessed with a high blood pressures and providers were notified even when a resident was asymptomatic.

During interview on 6/8/21, at 11:15 a.m. trained medical aide (TMA)-A stated nurses completed routine vitals including blood pressure checks; however, when the nurse was busy the TMA's and nursing assistants (NA)'s would do the vitals and they notified the nurse immediately when the readings were abnormal. TMA-A also stated the electronic medical record (EMAR) flagged after results were entered and alerted staff that the vitals readings were out of normal range.

During interview on 6/8/21, at 11:54 a.m. nurse manager RN-G stated the expectation was that staff notified the provider immediately with abnormal vitals signs including the elevated abnormal blood pressure results. RN-B further indicated that with R4's elevated systolic blood pressure above 160's mm hg, the nursing staff should have updated the provider immediately and the provider would have been the one to make the determination on how to proceed with the elevated results. RN-B verified facility staff did not document that R4's blood pressures were rechecked when elevated and R4's documents also lacked evidence that the provider was updated when R4's systolic blood pressures where elevated.

During interview on 6/8/21, at 1:51 p.m. the director of nursing (DON) stated when a resident was noted to have elevated abnormal blood pressure, the facility staff were expected to recheck the "old fashion" way and use the manual blood pressure cuff as sometimes the electronic blood pressure machine could read

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2 265	Continued From page 7	2 265		

erroneous results. The DON stated if blood pressure readings were consistently high, and the provider was not going to be in house, staff needed to call the provider. The DON further stated the EMAR flagged abnormal vitals results and alerted staff of the abnormal range.

Documentation that indicated the facility had updated the provider with elevated blood pressures for R4, and that elevated abnormally high blood pressure levels were rechecked immediately was requested and not provided.

R1's admission Minimum Data Set (MDS) identified R1 had a brief interview for mental status (BIMS) of 14 out of 15, indicated R1 was cognitively intact. R1 required extensive assistance with bed mobility, transfers, dressing, and toileting.

R1's Facesheet undated, indicated diagnoses that included hypertension (high blood pressure), congestive heart failure, orthostatic hypotension (drop in blood pressure with change in positioning), hypertensive urgency, renal insufficiency (poor kidney function), sepsis relating to a urinary tract infection, and Parkinson's disease.

R1's care plan dated 5/6/21, indicated R1 had high blood pressure (BP) readings and exhibited large drops in BP related to medications given to treat hypertension (HTN). A goal dated 5/6/21, identified R1's systolic BP would remain between 150 millimeters of mercury (mmHg) and 90 mmHg. Interventions included observation for signs and symptoms including fatigue and increased BP. Staff was instructed to assess vital signs and update the provider as needed.

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2 265	Continued From page 8 R1's Physician Orders Report, undated, indicated R1 received three medications to treat high blood presure: clonidine HCl, hydralazine and losartain. R1's Blood Pressure Vital Results dated 4/24/21, to 5/31/21, contained the following BP readings which lacked documentation of provider notification: - 4/24/21, 194/89 at 7:45 a.m. - 4/30/21, 187/87 at 9:25 p.m. - 5/1/21, 193/95 at 4:20 a.m. - 5/2/21, 191/85 at 9:21 a.m. - 5/4/21, 180/77 at 7:22 a.m. - 5/4/21, 69/40 at 1:09 p.m. - 5/9/21, 183/80 at 7:22 a.m. - 5/9/21, 188/84 at 8:47 p.m. - 5/9/21, 190/82 at 10:39 p.m. - 5/20/21, 180/91 at 9:10 p.m. - 5/21/21, 190/97 at 9:09 a.m. - 5/21/21, 208/88 at 8:52 p.m. - 5/22/21, 199/74 at 8:32 p.m. - 5/23/21, 182/84 at 7:19 a.m. - 5/25/21, 180/81 at 11:39 p.m. - 5/27/21,182/75 at 8:13 a.m. - 5/27/21, 58/38 at 11:43 a.m. - 5/29/21, 193/98 at 2:26 a.m. - 5/31/21, 197/92 at 8:34 p.m. When interviewed on 6/4/21, at 10:16 a.m. licensed practical nurse (LPN)-A stated if a resident's vital signs were abnormal she would call the nurse practitioner (NP)-A triage office to update the provider. When interviewed on 6/4/21, at 1:00 p.m. NP-A described R1 as having labile BPs (readings which ranged from very high to very low). NP-A stated she reviewed R1's progress notes and BP history and noted staff were inconsistent in	2 265		

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2 265	Continued From page 9	2 265		

providing updates. She stated if systolic BP was below 100 or above 180 she expected staff would have notified her as interventions may have been required. She stated she had discussed this with a nurse manager and many bedside nurses, and staff were aware of the expectations relating to house standing orders.

When interview on 6/4/21, at 2:04 p.m. registered nurse (RN)-A stated if a resident's BP was abnormal she would recheck it, give water, and given PRN medications if ordered. She would recheck the resident in 30 minutes to one hour.

When interviewed on 6/4/21, at 2:16 p.m. nursing assistant (NA)-A stated R1's BP fluctuated often. When R1's BP was low she became fatigued and NA-A placed R1 in bed, elevated R1's feet until she was stable, and informed the nurse.

When interviewed on 6/4/21, at 2:42 p.m. NA-B stated when she obtained a low BP reading she would obtain a second BP, asked the resident what their normal BP was, encouraged water, and reported to the nurse.

When interviewed on 6/6/21, at 3:29 p.m. RN-B stated she expected the NAs to tell her if they obtained abnormal BP readings. She stated there were standing house orders which instructed staff to notify a provider if a systolic BP was above 140 or below 60. She treated the resident's BP with PRN (as needed) medications if ordered, rechecked the BP one hour later, and updated the NP.

When interviewed on 6/6/21, at 3:40 p.m. RN-C stated if an NA reported an abnormal BP for a resident she checked them again herself. If BP was still not within normal range she assessed

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2 265	Continued From page 10	2 265		

the resident, gave a PRN medication if ordered, and notified the provider regardless of the efficacy of the given medication. She stated if a resident had a systolic BP of 170 or higher she would definitely call the provider, monitor the resident, and document a note in the record.

When interviewed on 6/6/21, at 3:54 p.m. RN-D stated if BP readings were abnormal staff took them again. If they were still abnormal staff were expected to tell the nurse who would check them manually. If they were still abnormal RN-D expected staff to notify the provider. RN-D reviewed progress notes for R1 and was unable to locate documentation of provider notification for each instance of abnormal BP readings.

When interviewed on 6/7/21, at 2:01 p.m. R1's physician (MD)-A stated if a resident had a high BP he would expect staff to perform a manual BP check and assess the resident. He stated he expected to be notified if the resident's BP was below 70 systolic, above 160 systolic with symptoms, or above 180 regardless of the presence of symptoms. He also stated that they [facility staff] were supposed to document provider notification.

The facility Standing House Order policy was requested and not provided.

The facility Change in Condition policy undated, directed staff to assess significant change in the resident's condition noted through direct observation, interview or report from the other staff. Facility staff were to notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If staff were unable to contact the physician, they were to contact the

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2 265	Continued From page 11 Medical Director as appropriate. The community was to immediately inform the resident, consults with the resident representative when there was significant change in the resident's physical, mental or psychosocial status, or when there was the need to alter treatment significantly. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to catheter cares, skin assessments, and vitals monitoring and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by:	2 830		7/15/21

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2 830	Continued From page 12 Based on observation, interview and document review, the facility failed to ensure indwelling catheter management and skin assessments were completed to prevent erosion (tearing) of the penile urethral (opening for urine to pass out of body) for 1 of 3 resident (R4), whom had an indwelling urinary catheter. This caused actual harm for R4. Findings include: R4's Face Sheet printed 6/8/21, indicated diagnoses that included neuromuscular dysfunction of bladder (a condition that results in loss of control of the bladder), unspecified obstructive and reflux uropathy (the obstruction of urine flow to the bladder from the kidneys and the flow of urine flowing backward into the kidneys), benign prostatic hyperplasia (enlarged prostate gland) with urinary tract symptoms, chronic kidney disease stage 3 (when the kidneys are not working well, causing swelling in hands and feet, back pain, and urinating more or less than normal). R4's admission Minimum Data Set dated 4/14/21, indicated R4 was admitted in 4/21, had severe cognitive impairment, required extensive assist of two staff for toileting, bed mobility and transfers with Care Area Assessment triggered for urinary incontinence and indwelling catheter. R4's care plan dated 4/9/21, indicated R4 required an indwelling urinary catheter (a tube that goes into the bladder to empty it and remains in place) related to neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), with urinary retention and interventions included use of a catheter strap (used to keep indwelling urinary catheter	2 830	Corrected	

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2 830	Continued From page 13	2 830		

secured), and to document urinary output every shift. Staff were to change the indwelling urinary catheter monthly and as needed (PRN). Staff were also to record the amount, type, color, odor and observe for leakage.

R4's care plan dated 4/9/21, lacked documentation for monitoring R4's skin for irritation with the use of the indwelling urinary catheter.

R4's Physician Orders Report dated 4/8/21, indicated to record indwelling urinary catheter output every shift; to change the indwelling urinary catheter every four weeks; and to use a leg bag when up and night drainage bag when in bed.

R4's Admission Body Audit: Skin Condition dated 4/8/21, lacked assessment of any penile skin irritation.

R4's Admission Body Audit: Skin Condition dated 4/15/21, lacked assessment of any penile skin irritation.

R4's Skin Risk Assessment with Braden Scale dated 4/27/21, lacked assessment of any penile skin irritation.

R4's Progress notes dated 5/2/21, at 2:11 p.m. indicated R4's indwelling urinary catheter replaced, 16 French (Fr) 10 cubic centimeters (cc) balloon with light yellow urine return. Resident tolerated insertion with some discomfort but stated he was alright once catheter was in place. Declined pain medication. There was no mention of any penile skin irritation or erosion.

R4's Skin Risk Assessment with Braden Scale

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2 830	Continued From page 14 dated 5/3/21, lacked assessment of any penile skin irritation. R4's progress notes dated 5/5/21, at 12:50 p.m. indicated updated nurse practitioner (NP) on appearance of meatus (a passage or opening leading to the interior of the body) and glans penis (tip of the penis). Order received for urology referral for indwelling urinary catheter erosion concerns and evaluation for placement of supra-pubic catheter. R4's NP progress notes dated 5/5/21, printed at 9:40 p.m. indicated: nursing staff also expressed concerns with the indwelling urinary catheter . They reported that part of the catheter could be seen farther down on his penis. There was concern for further opening or erosion around the insertion site of the indwelling urinary catheter. The note further indicated R4 was seen in his wheelchair on 5/5/21, and the NP was unable to examine his private areas. NP discussed with staff and was going to refer to urology for evaluation. R4's physician orders dated 5/5/21, indicated schedule appointment with urology for indwelling urinary catheter erosion concerns and evaluation for supra-pubic catheter (SP-catheter inserted into the bladder via the anterior abdominal wall). R4's physician orders dated 5/17/21, indicated appointment on Tuesday 5/25/21, at 12:50 p.m. at a urology clinic. R4's progress notes dated 5/25/21, indicated R4 returned from urology appointment with new orders for placement of a suprapubic (SP) catheter with follow up appointment with urology in a month.	2 830		

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2 830	Continued From page 15 R4's physician orders dated 5/27/21, indicated an appointment on Thursday 6/3/21, at 12:00 p.m. for a SP catheter placement at a local hospital R4's physician orders dated 6/8/21, indicated R4 must be "nothing by mouth" (NPO) after 5:00 a.m. on Tuesday 6/8/21 due to SP catheter placement. Notes from R4's urology appointments were requested and not provided by the facility. Several attempts were made to interview the urologist were unsuccessful . During an observation on 6/4/21, at 11:20 a.m. R4 was in dining room sitting at a table with his indwelling urinary catheter drainage leg bag visible below his left pants leg. R4's foley catheter straps were hanging loose around his left ankle and not securing the tubing to his leg causing pulling/pressure of the catheter on his penile urethral meatus. During an observation on 6/7/21, at 3:31 p.m. registered nurse (RN)-B and nursing assistant (NA)-A entered R4's room to assist with getting R4 out of bed and into his wheelchair. RN-B lifted R4's penis and explained that the split under the penis was the erosion and R4 had some reddened irritation. R4 had an approximate one-to-two-inch split under his penis from his urethral down the meatus downward at the base of his penis. The catheter was visible inside the split area entering the urethral duct (transmits urine from the bladder to the exterior of the body during urination). During an observation on 6/8/21, at 9:25 a.m. R4 was in bed lying on his left side. R4's catheter drain bag was within the privacy pouch attached	2 830		

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2 830	Continued From page 16 onto R4's bed frame. R4's lower indwelling urinary catheter leg strap was not attached to resident but was on the catheter tubing line, near the drainage bag. The second leg strap for the indwelling urinary catheter tubing was unattached to R4's body but under R4's left ankle area. The lack of a securely placed leg strap could result in pulling of the indwelling urinary catheter causing more pull on the urethra and could have further worsened any penile skin irritation or erosion. During interview on 6/7/21, at 1:02 p.m. nurse practitioner (NP)-A stated R4 had penile urethral erosion at the base of his penis was caused from catheter use and she was unaware of this until the facility staff notified her on 5/5/21. NP-A stated that she had been unable to visually assess R4's perineal area or catheter insertion site/penis as R4 was usually up in his wheelchair (W/C) or was asleep during rounds. NP-A stated she typically read progress notes when she completed routine visits and had not seen any mention in the progress notes about the urethral erosion prior to 5/5/21 by the facility staff. NP-A further stated R4 was admitted 4/8/21, and she saw each resident at least once a month but was on campus at the facility at least three times per week. NP-A stated the facility staff had access to contact the provider when not onsite, 24 hours per day. NP-A stated she had communicated to facility nurses and managers her expectation of notifying providers with change in condition in residents. NP-A stated an order for urology consult was placed on 5/5/21, after staff had updated her on R4's penile urethral erosion. NP-A stated had the facility assessed and monitored R4's catheter insertion site and updated NP-A timely of the penile urethral erosion, the penile urethral erosion may have been avoidable.	2 830		

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2 830	Continued From page 17 During interview on 6/7/21, at 2:45 p.m. licensed practical nurse (LPN)-C stated she had changed R4's foley catheter on 5/2/21, and noted the penile urethral erosion. LPN-C stated she thought she had updated the NP but was unable to find the documentation. LPN-C stated, on 5/5/21, she documented she had informed the NP of the penile urethral erosion and had received referral orders for urology consult. During interview on 6/7/21, at 3:45 p.m. RN-B stated R4 was noted to have the penile urethral erosion when RN-B worked with R4 during peri cares, a few days after his admission. RN-B stated R4's penis definitely looked different and was unusual with the erosion beginning at the meatus into the base of R4's penis and it looked irritated. RN-B further stated she could not recall if she had charted on the penile urethral erosion and had assumed it was at baseline for the R4, since R4 had urology issues in the past and that there was no active bleeding. RN-B indicated she had verbally informed the night shift about the penile urethral erosion but was unable to remember who the night nurse was. RN-B also stated several nursing assistants had come and verbalized their concerns about the catheter to her on different days. RN-B also stated in retrospect she should have notified the nurse manager and the provider about the penile urethral erosion immediately and should have also updated the nursing assistant care sheets on cleaning the site properly. RN-B verified that she had not updated the provider and did not document in R4's progress notes or skin assessments concerning the penile urethral erosion. During interview on 6/7/21, at 4:28 p.m. family member (FM)-A stated he had not been updated	2 830		

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2 830	Continued From page 18	2 830		

regarding any issues with R4's penile urethral erosion, until sometime in May 2021 when he was informed that R4 was to be seen by a urologist due to penile urethral erosion. FM-A also stated the previous facility had not mentioned any issues with R4's prior to his discharge. Initially R4 went to the urologist while at a previous facility; but due to COVID-19, the nurses had been changing the catheter onsite while at the previous facility. FM-A stated, R4 had not had any concerns about erosions communicated to him by the previous facility prior to discharge.

During interview on 6/7/21, at 4:40 p.m. FM-B stated she had come to visit R4 while residing at current facility and observed catheter straps (which prevented pulling of the foley catheter from the urethra) were not in place and the catheter tubing looked dirty.

During telephone interview on 6/8/21, at 8:57 a.m. LPN-D, who worked at the facility where R4 previously resided, stated when R4 was discharged from the previous facility he had no skin issues with his foley catheter. LPN-D stated if resident had any skin conditions it would have been documented and stated R4 had no openings with his penis while at their facility. LPN-D also verified that she had changed R4's catheter several times and noted no skin issues or abnormalities. LPN-D further stated R4's catheter was last changed on 4/5/21, at the previous facility and there was no indication of skin issues that were identified in the documents.

During interview on 6/8/21, at 11:15 a.m. trained medication aide (TMA)-A stated she had worked with R4 within several days after his admission to the facility and observed his penis was split at the bottom and looked different. TMA-A stated she

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2 830	Continued From page 19	2 830		

immediately verbally informed the nurse on duty, and further stated only the nurses completed the skin assessments.

During interview on 6/8/21, at 11:54 p.m. unit manager (RN)-G stated she had called the previous facility R4 resided at and was informed by the staff at previous facility that R4 did not have any skin concerns with his foley catheter. RN-G stated there was no indication on the current facility's admission skin assessment that identified penile urethral erosion. RN-G also verified the nursing progress notes and skin assessments from admission on 4/8/21 through 5/4/21, lacked documentation of R4's penile urethral irritation or erosion.

During interview on 6/8/21, at 1:51 p.m. the director of nursing (DON) stated she was informed that R4 possibly had the penile urethral erosion upon admission; however, there was no documentation to show this was present on admission. DON stated it was the expectation that the admitting nurse did a thorough skin assessment and documented findings of abnormal skin conditions in the resident's chart. It was also the expectation that staff informed other nursing staff if a resident had a penile urethral erosion for continued monitoring and to also immediately notify the provider with this assessment finding.

The facility Prevention of Catheter-Associated Urinary Tract Infections Policy updated 12/29/17 indicated when a resident was admitted to the facility with a catheter in place, a thorough physical assessment as well as history review was to be completed. Catheter were to be Secured to avoid pulling and trauma to the bladder and urethra. The peri-urethra was

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cleaned regularly with mild soap and water and then rinsed. Staff were to always wash from the area of least contamination to the area of greatest and wipe from front to the back.

The facility Resident Examination and Assessment Policy undated, indicated a through resident examination and assessment was to capture any abnormalities in health status, physical function, or an acute change in condition. This assessment was to provide the basis for the initial care plan, as well as provide additional updates to care plan as indicated. Physical exam and or refusals were to be documented in the Electronic Health Record.

The facility Prevention and Treatment of Skin Breakdown Policy undated indicated skin integrity is monitored, and abnormal findings were to be documented. Skin was to be observed daily with cares. If any skin concerns were noted, they were to be reported to the licensed nurse. Weekly skin audits were to be performed by a licensed nurse.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents with catheter urethral skin issues, abnormalities or erosions to assure they are receiving ongoing monitoring and assessment of the skin along with the necessary treatment/services to prevent worsening and that providers are notified of identified skin abnormalities or erosions. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of these skin issues not being cared for properly.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 830	Continued From page 21 (21) days.	2 830		