

Protecting, Maintaining and Improving the Health of All Minnesotans

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 Therefore, the NATCEP prohibition is rescinded.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,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Cerenity - Marian Of St Paul LLC August 5, 2021 Page 2 Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>



Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>



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

Cerenity - Marian Of St Paul LLC July 1, 2021 Page 2

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 Cerenity - Marian Of St Paul LLC July 1, 2021 Page 3 Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900 Email: <u>susan.frericks@state.mn.us</u> 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,

Cerenity - Marian Of St Paul LLC July 1, 2021 Page 4

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	`´co⊮	E SURVEY IPLETED
		245365	B. WING				C /08/2021
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F 000	INITIAL COMMENT	ſS	F 0	00			
	abbreviated survey Your facility was for with the requirement Requirements for L The following comp	6/8/21, a standard was conducted at your facility. und to be NOT in compliance hts of 42 CFR 483, Subpart B, ong Term Care Facilities.					
	SUBSTANTIATED: H5365045C (MN73 deficiencies cited a	407; MN73192), with					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 580 SS=D	onsite revisit of you validate that substa regulations has bee Notify of Changes (Injury/Decline/Room, etc.)	F 5	80			7/15/21
	 (i) A facility must im consult with the res consistent with his of representative(s) w (A) An accident inver- results in injury and physician interventi (B) A significant char mental, or psychoso- deterioration in hear 	olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						07/09/2021

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.

	IULTIPLE CONSTRUCTION (X3) DATE SURVEY LDING COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU	C
245365 B. WI	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY - MARIAN OF ST PAUL LLC	200 EARL STREET SAINT PAUL, MN 55106
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	D PROVIDER'S PLAN OF CORRECTION (X5) EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
 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 	This plan of correction is not an

Facility ID: 00354

If continuation sheet Page 2 of 20

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	TPLE CONSTRUCTION	OMB NO.	E SURVEY
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	review, the failed to (tendency to chang blood pressure) and	notify the provider of labile e from really high to really low d abnormal blood pressure residents (R1, R4) reviewed		admission of guilt on behalf of th provider. This plan of correction submitted because it is required	is being	
	Findings include:			Resident #1 is no longer residing facility. Resident #4 s BP s ar monitored per the plan of care a	e nd	
ן ג (נ	hypertensive chroni blood pressure cau	inted 6/8/21, indicated c kidney disease (elevated sed by kidney disease) with		abnormal results are communica NP/MD based on the individualiz parameters set.	ed	
	(indicates advanced arteriosclerotic heat	ge 4 chronic kidney disease d kidney damage), rt disease of native coronary the artery of the heart that can		Residents BP s are monitored MD/NP orders or their individual of care. Abnormal BP s obtained the vital signs machines are re-o	zed plan ed from	
	cause heart attacks (severe pain in the) without angina pectoris chest, often also spreads to and orthostatic hypotension		with a manual cuff per policy. N be updated on abnormal BP rea facility policy.	P/MD will dings per	
	millimeter of mercu	sure decrease of at least 20 ry (mm hg which is a pressure) or a diastolic blood		Parameters for BP readings hav established for guidance to staff contacting the NP/MD. Staff hav	on	
	pressure decrease three minutes of sta	of at least 10 mm Hg within anding.		re-educated on the facility s pol regarding obtaining BPs and NP notification. Education began or	/MD	
	indicated R4 had se with diagnoses that	imum Data Set dated 4/14/21, evere cognitive impairment included atrial fibrillation (an rapid heart rate) or other		and will continue until all nursing have been re-educated. The DON, or her designee, will a abnormal BP readings 5Xs per v	audit all	
	dysrhythmias (abno artery disease (dev vessels that supply	rmal heart rhythms), coronary elops when the major blood your heart become damaged		4, then 3Xs per week for 2 week then 1 time per week for 2 week ensure NP/MD notification. Issu	s, and s to es	
	pressures).	pertension (high blood		identified will be referred to the f QAPI Team for input/suggestion Team.	s from the	
	elevated systolic blo diagnosis of hyperte	ated 4/27/21, indicated R4 had bod pressure readings with ension, with the goal to bod pressure reading under		The DON is responsible for ensu abnormal BPs requiring MD/NP notification are reported to the p	-	

Facility ID: 00354

If continuation sheet Page 3 of 20

	-	AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPI	LE CONSTRUCTION	(X3) DAT	E SURVEY
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		245365	B. WING			C 06/08/2021	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CERENIT	TY - MARIAN OF ST P	AUL LLC			200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 580	Continued From pa	ana 3	F 5	20			
		al doctor (MD) orders and	1.5	00	, ,		
		ers and update MD as					
	R4's Physician Ord	ers Report dated 4/8/21,					
		e (medication used to treat					
		e) 5 milligrams (mg), give one at bedtime at 8:00 p.m.					
	R4's Physician Ord	ers Report dated 6/4/21,					
	indicated amlodipin	e 5 mg tablet, give 10 mg					
	orally at bedtime at	8:00 p.m.					
		e Vital Results dated 4/8/21,					
	elevated blood pres	the following abnormal ssure results:					
	- 4/8/21, 212/96 at 6	6:14 p.m.					
	- 4/8/21, 190/82 at 9 - 4/9/21, 178/78 at 2						
	- 4/9/21, 170/71 at 6	6:07 a.m.					
	- 4/10/21, 178/80 at - 4/10/21, 170/81 at						
	- 4/11/21, 176/75 at	t 04:36 a.m.					
	- 4/13/21, 171/79 at - 4/14/21, 180/76 at						
	- 4/15/21, 171/72 at	•					
	- 4/16/21, 160/72 at						
	- 4/17/21, 184/79 at - 4/25/21, 165/60 at						
	- 5/8/21, 190/79 at 5	•					
	- 5/8/21: 171/85 at 9 - 5/22/21: 170/75 at	•					
		e Vital Results dated 4/8/21,					
		ocumentation that blood					
		n rechecked after elevated essure results were taken or					
	and lacked evidenc updated.	e the provider had been					

Facility ID: 00354

If continuation sheet Page 4 of 20

		AND HUMAN SERVICES					FORM	07/19/2021 APPROVED 0938-0391	
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CERENI	TY - MARIAN OF ST P	AUL LLC			200 EARL STREET SAINT PAUL, MN 55106				
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F 580	Continued From pa	ge 4	F	580					
	practitioner (NP)-A progress notes whe and had not seen a notes about the ure by the facility staff. admitted 4/21, and once a month and y facility at least three the facility staff had provider when not of stated she had com and managers her providers with chan NP-A also stated th providers when blog abnormal. During interview on primary medical do expected when resi that the facility staff assessment to dete headaches. MD-A e intervene by having recheck blood pres pressure machine a than the electronic MD-A also stated if pressure readings f regarding the range notification to the put that residents with o were assessed with providers were notif asymptomatic.	6/7/21, at 1:02 p.m. nurse stated she typically read en she completed routine visits ny mention in the progress thral erosion prior to 5/5/21, NP-A further stated R4 was she saw each resident at least was also on campus at the e times per week. NP-A stated access to contact the onsite, 24 hours per day. NP-A municated to facility nurses expectation of notifying ges in resident condition. e facility had not updated od pressure readings were 6/7/21, at 2:15 p.m. R4's ctor (MD)-A indicated it was idents had high blood pressure completed a neurological ermine the presence of explained facility staff were to resident lay down and sure using a manual blood as this was more accurate blood pressure machine. a resident had high blood facility staff had a policy e of BP that required rovider. It was the expectation ongoing high blood pressures a high blood pressures and fied even when a resident was							

Facility ID: 00354

If continuation sheet Page 5 of 20

		AND HUMAN SERVICES				FORM	07/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
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F 580	routine vitals includ however, when the and nursing assista and they notified the readings were above electronic medical results were entered vitals readings were During interview on manager RN-G star staff notified the pro- abnormal vitals sign abnormal blood pre- indicated that with F pressure above 160 should have update and the provider wor make the determina the elevated results not document that F rechecked when elevated also lacked evidend updated when R4's where elevated. During interview on director of nursing (was noted to have of pressure, the facility recheck the "old fas manual blood press electronic blood pre- grovider was not go needed to call the p	ge 5)-A stated nurses completed ing blood pressure checks; nurse was busy the TMA's ints (NA)'s would do the vitals e nurse immediately when the ormal. TMA-A also stated the record (EMAR) flagged after d and alerted staff that the e out of normal range. 6/8/21, at 11:54 a.m. nurse ted the expectation was that ovider immediately with ns including the elevated essure results. RN-B further R4's elevated systolic blood D's mm hg, the nursing staff ed the provider immediately ould have been the one to ation on how to proceed with 5. RN-B verified facility staff did R4's blood pressures were evated and R4's documents be that the provider was systolic blood pressures 6/8/21, at 1:51 p.m. the (DON) stated when a resident elevated abnormal blood y staff were expected to shion" way and use the sure cuff as sometimes the essure machine could read The DON stated if blood were consistently high, and the bing to be in house, staff provider. The DON further agged abnormal vitals results	F 5	580			

If continuation sheet Page 6 of 20

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY
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CERENII	Y - MARIAN OF ST P	AUL LLC			200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG				x	(X5) COMPLETION DATE		
F 580	Documentation that updated the provide pressures for R4, a high blood pressure immediately was re R1's admission Min identified R1 had a status (BIMS) of 14 cognitively intact. R assistance with bed and toileting. R1's Facesheet und that included hypert congestive heart fai (drop in blood press positioning), hyperte insufficiency (poor H relating to a urinary Parkinson's disease R1's care plan date high blood pressure large drops in BP re treat hypertension (identified R1's syste 150 millimeters of m mHg. Interventior signs and symptom increased BP. Staff signs and update th R1's Physician Orde R1 received three m presure: clonidine H	the abnormal range. the abnormal range. tindicated the facility had er with elevated blood and that elevated abnormally e levels were rechecked quested and not provided. imum Data Set (MDS) brief interview for mental out of 15, indicated R1 was 1 required extensive I mobility, transfers, dressing, dated, indicated diagnoses tension (high blood pressure), ilure, orthostatic hypotension sure with change in ensive urgency, renal kidney function), sepsis tract infection, and e. d 5/6/21, indicated R1 had e (BP) readings and exhibited elated to medications given to HTN). A goal dated 5/6/21, blic BP would remain between nercury (mmHg) and 90 as included observation for s including fatigue and was instructed to assess vital the provider as needed. ers Report, undated, indicated hedications to treat high blood iCI, hydralazine and losartain.	F 5	\$80	DEFICIENCY)		
		ICI, hydralazine and losartain. e Vital Results dated 4/24/21,					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM): 07/19/202 / APPROVE). 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245365	B. WING			06	6/08/2021
NAME OF F	PROVIDER OR SUPPLIER	1		STF	REET ADDRESS, CITY, STATE, ZIP C		
CERENIT	Y - MARIAN OF ST F	PAUL LLC			EARL STREET INT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	• · · · · · · · · · · · · · · · · · · ·	age 7 ed the following BP readings	F 5	80			
		mentation of provider					
	- 4/24/21, 194/89 a - 4/30/21, 187/87 a - 5/1/21, 193/95 at	t 9:25 p.m.					
	- 5/2/21, 191/85 at - 5/4/21, 180/77 at - 5/4/21, 69/40 at 1	7:22 a.m. :09 p.m.					
	- 5/9/21, 183/80 at - 5/9/21, 188/84 at - 5/9/21, 190/82 at - 5/20/21, 180/91 a	8:47 p.m. 10:39 p.m.					
	- 5/21/21, 100/91 a - 5/21/21, 190/97 a - 5/21/21, 208/88 a - 5/22/21, 199/74 a	t 9:09 a.m. t 8:52 p.m.					
	- 5/23/21, 182/84 a - 5/25/21, 180/81 a - 5/27/21,182/75 at	t 7:19 a.m. t 11:39 p.m.					
	- 5/27/21, 58/38 at - 5/29/21, 193/98 a - 5/31/21, 197/92 a	t 2:26 a.m.					
	licensed practical r resident's vital sign	on 6/4/21, at 10:16 a.m. hurse (LPN)-A stated if a is were abnormal she would titioner (NP)-A triage office to r.					
	described R1 as ha which ranged from stated she reviewe history and noted s	on 6/4/21, at 1:00 p.m. NP-A aving labile BPs (readings very high to very low). NP-A d R1's progress notes and BP staff were inconsistent in She stated if systolic BP was					
	below 100 or above have notified her as	e 180 she expected staff would s interventions may have been d she had discussed this with					

Facility ID: 00354

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		IDENTIFICATION NONIBER.	A. BUILDI	ING			C
		245365	B. WING			06/	08/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY - MARIAN OF ST P	AUL LLC			SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	a nurse manager an staff were aware of house standing orde When interview on a nurse (RN)-A stated abnormal she would given PRN medicat recheck the residen When interviewed of assistant (NA)-A sta When R1's BP was NA-A placed R1 in R she was stable, and When interviewed of stated when she ob would obtain a seco what their normal B reported to the nurs When interviewed of stated she expected obtained abnormal were standing hous to notify a provider i or below 60. She tre PRN (as needed) m rechecked the BP of the NP. When interviewed of stated if an NA repor- resident she checked was still not within m the resident, gave a	and many bedside nurses, and the expectations relating to ers. 6/4/21, at 2:04 p.m. registered d if a resident's BP was d recheck it, give water, and ions if ordered. She would at in 30 minutes to one hour. on 6/4/21, at 2:16 p.m. nursing ated R1's BP fluctuated often. low she became fatigued and bed, elevated R1's feet until d informed the nurse. on 6/4/21, at 2:42 p.m. NA-B tained a low BP reading she ond BP, asked the resident P was, encouraged water, and se. on 6/6/21, at 3:29 p.m. RN-B d the NAs to tell her if they BP readings. She stated there we orders which instructed staff if a systolic BP was above 140 eated the resident's BP with hedications if ordered, one hour later, and updated on 6/6/21, at 3:40 p.m. RN-C orted an abnormal BP for a ed them again herself. If BP normal range she assessed a PRN medication if ordered,	F 5	80			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From para a nurse manager ar staff were aware of house standing orde When interview on nurse (RN)-A stated abnormal she would given PRN medicat recheck the residen When interviewed of assistant (NA)-A stated abnormal she would given PRN medicat recheck the residen When interviewed of assistant (NA)-A stated when R1's BP was NA-A placed R1 in H she was stable, and When interviewed of stated when she ob would obtain a seco what their normal B reported to the nurse When interviewed of stated she expected obtained abnormal were standing hous to notify a provider if or below 60. She tree PRN (as needed) m rechecked the BP of the NP. When interviewed of stated if an NA repor- resident she checked was still not within m the resident, gave a and notified the pro-	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 8 nd many bedside nurses, and the expectations relating to ers. 6/4/21, at 2:04 p.m. registered d if a resident's BP was d recheck it, give water, and ions if ordered. She would at in 30 minutes to one hour. on 6/4/21, at 2:16 p.m. nursing ated R1's BP fluctuated often. low she became fatigued and bed, elevated R1's feet until d informed the nurse. on 6/4/21, at 2:42 p.m. NA-B tained a low BP reading she ond BP, asked the resident P was, encouraged water, and se. on 6/6/21, at 3:29 p.m. RN-B d the NAs to tell her if they BP readings. She stated there are orders which instructed staff if a systolic BP was above 140 eated the resident's BP with hedications if ordered, one hour later, and updated	PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPL

If continuation sheet Page 9 of 20

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	07/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	0	(X3) DATI COM	E SURVEY PLETED
		245365	B. WING	i				C 08/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
CERENI	TY - MARIAN OF ST P	AUL LLC			200 EARL STREET SAINT PAUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 9	F	580				
	would definitely call	olic BP of 170 or higher she the provider, monitor the nent a note in the record.						
	stated if BP reading them again. If they expected to tell the manually. If they we expected staff to no reviewed progress to locate document	on 6/6/21, at 3:54 p.m. RN-D is were abnormal staff took were still abnormal staff were nurse who would check them ere still abnormal RN-D otify the provider. RN-D notes for R1 and was unable ation of provider notification f abnormal BP readings.						
	physician (MD)-A st BP he would expect check and assess t expected to be notifiable of the symptoms, or above presence of symptoms	on 6/7/21, at 2:01 p.m. R1's cated if a resident had a high t staff to perform a manual BP he resident. He stated he fied if the resident's BP was bove 160 systolic with e 180 regardless of the oms. He also stated that they supposed to document h.						
	The facility Standing requested and not p	g House Order policy was provided.						
	directed staff to ass resident's condition observation, intervia staff. Facility staff w provider of the char implement orders for monitoring as direc contact the physicia Medical Director as	in Condition policy undated, sess significant change in the noted through direct ew or report from the other vere to notify the attending nge in condition and or treatment and appropriate ted. If staff were unable to an, they were to contact the appropriate. The community inform the resident, consults						

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	E SURVEY
D PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245265	B. WING			C
	PROVIDER OR SUPPLIER	245365	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	08/2021
				200 EARL STREET		
ERENI	TY - MARIAN OF ST P	AUL LLC		SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 580	with the resident re significant change i mental or psychoso	ge 10 presentative when there was n the resident's physical, icial status, or when there was atment significantly.	F 58	0		
	Quality of Care CFR(s): 483.25	autorit orginiloarity.	F 68	4		7/15/21
	applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro practice, the compr care plan, and the r This REQUIREMEN by: Based on observat	NT is not met as evidenced ion, interview and document		Resident #4 had a suprapubic cath		
	review, the facility fact the review management were completed to the penile urethral (of body) for 1 of 3 review.	ailed to ensure indwelling ent and skin assessments prevent erosion (tearing) of opening for urine to pass out esident (R4), whom had an atheter. This caused actual	velling sments aring) of b pass outinserted on 6/8/2021. Resid continues to be monitored pr policy.a had an d actualA list of residents with an ind suprapubic catheter has bee These residents are provide catheter care and weekly sk assessments to prevent gen Staff were re-educated on catheter care	 inserted on 6/8/2021. Resident #4 continues to be monitored per facili policy. A list of residents with an indwelling suprapubic catheter has been deve These residents are provided daily catheter care and weekly skin assessments to prevent genital irrit Staff were re-educated on catheter 	s skin ty or loped. ation.	
	diagnoses that inclu dysfunction of blade loss of control of the obstructive and refl urine flow to the bla flow of urine flowing benign prostatic hyp	inted 6/8/21, indicated uded neuromuscular der (a condition that results in e bladder), unspecified ux uropathy (the obstruction of dder from the kidneys and the g backward into the kidneys), perplasia (enlarged prostate tract symptoms, chronic		 and management on 7/8/2021 and education will continue until all nurs staff have been re-educated. Education included skin monitoring to prevent breakdown. The DON, or her designee, will perform audits on each resident with a cathor 4 weeks, 2 audits on each resident catheter for 4 weeks, and then 1 auticatheter for 4 weeks, and then 1 auticatheter 	ation skin form 3 eter for with a	

Facility ID: 00354

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
ID PLAN C	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			C
		245365	B. WING			08/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
CERENI	TY - MARIAN OF ST P	AUL LLC		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 684	Continued From pa	ge 11	F 684			
	working well, causi	ge 3 (when the kidneys are not ng swelling in hands and feet, ating more or less than		catheter for 4 weeks. Issues i with catheter care and skin as will be forwarded to the facility Team for input/suggestions fro Team.	sessment 's QAPI	
	indicated R4 was a cognitive impairment two staff for toileting	timum Data Set dated 4/14/21, dmitted in 4/21, had severe nt, required extensive assist of g, bed mobility and transfers essment triggered for urinary dwelling catheter.		The DON is responsible for er daily catheter care and weekly assessments are completed p policy.	/ skin	
	required an indwelli that goes into the b in place) related to bladder control due nerve problem), wit interventions includ (used to keep indw secured), and to do shift. Staff were to do catheter monthly an	d 4/9/21, indicated R4 ing urinary catheter (a tube ladder to empty it and remains neurogenic bladder (lack of to a brain, spinal cord or h urinary retention and ed use of a catheter strap elling urinary catheter ocument urinary output every change the indwelling urinary and as needed (PRN). Staff the amount, type, color, odor kage.				
		ed 4/9/21, lacked monitoring R4's skin for se of the indwelling urinary				
	indicated to record output every shift; t urinary catheter eve	ers Report dated 4/8/21, indwelling urinary catheter o change the indwelling ery four weeks; and to use a nd night drainage bag when in				

		AND HUMAN SERVICES				FORM	APPROVED				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY				
		245365	B. WING								
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	50/2021				
CERENIT	TY - MARIAN OF ST P	AUL LLC			200 EARL STREET						
					SAINT PAUL, MN 55106						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE				
E 694	Our times of France and	40	– – –								
F 684	• · · · · · · · · · · · · · · · · · · ·	ige 12 essment of any penile skin	F 6	84			(X5) COMPLETION				
	irritation.	SSILIENT OF ANY PETILE SKIT					COMPLETION				
		dy Audit: Skin Condition dated ressment of any penile skin									
		essment with Braden Scale ed assessment of any penile									
	indicated R4's indw replaced, 16 French (cc) balloon with lig Resident tolerated i but stated he was a place. Declined pair	s dated 5/2/21, at 2:11 p.m. velling urinary catheter h (Fr) 10 cubic centimeters ht yellow urine return. insertion with some discomfort alright once catheter was in n medication. There was no ile skin irritation or erosion.									
		essment with Braden Scale d assessment of any penile									
	indicated updated n appearance of mea leading to the interio penis (tip of the per referral for indwellin	s dated 5/5/21, at 12:50 p.m. nurse practitioner (NP) on atus (a passage or opening or of the body) and glans his). Order received for urology ng urinary catheter erosion lation for placement of er.									
	9:40 p.m. indicated concerns with the ir They reported that seen farther down of	notes dated 5/5/21, printed at : nursing staff also expressed ndwelling urinary catheter . part of the catheter could be on his penis. There was opening or erosion around the									

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		AND HUMAN SERVICES				FORM	APPROVED
	CARENCIES	& MEDICAID SERVICES	(X2) MULT		PLE CONSTRUCTION		. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			G		IPLETED
							С
		245365	B. WING	-		06/	08/2021
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	TY - MARIAN OF ST P	AUL LLC			200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTIC		(X5)
PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULI) BE	COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
					-		
F 684	Continued From pa	ige 13	F 6	684	1		
	insertion site of the indwelling urinary catheter.						
		dicated R4 was seen in his					
		21, and the NP was unable to areas. NP discussed with					
		to refer to urology for					
	evaluation.						
	R4's physician orde	ers dated 5/5/21, indicated					
	schedule appointme	ent with urology for indwelling					
		osion concerns and evaluation					
		heter (SP-catheter inserted the anterior abdominal wall).					
		the differior appointment wang.					
		ers dated 5/17/21, indicated					
		esday 5/25/21, at 12:50 p.m. at					
	a urology clinic.						
		s dated 5/25/21, indicated R4					
		gy appointment with new					
		nt of a suprapubic (SP)					
	in a month.	up uppointment with drology					
		ers dated 5/27/21, indicated an ursday 6/3/21, at 12:00 p.m.					
		acement at a local hospital					
		ers dated 6/8/21, indicated R4					
		y mouth" (NPO) after 5:00 a.m. due to SP catheter placement.					
		ology appointments were					
		provided by the facility. Several le to interview the urologist					
	were unsuccessful						
		ion on 6/4/21, at 11:20 a.m. om sitting at a table with his					
		atheter drainage leg bag					

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		AND HUMAN SERVICES				FORM	07/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245365	B. WING	i			C 08/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENIT	TY - MARIAN OF ST P	AUL LLC			00 EARL STREET AINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ige 14	Ff	684			
	visible below his lef straps were hanging and not securing th	t pants leg. R4's foley catheter g loose around his left ankle e tubing to his leg causing the catheter on his penile					
	registered nurse (R (NA)-A entered R4's R4 out of bed and in R4's penis and expl penis was the erosi reddened irritation. one-to-two-inch spli urethral down the m of his penis. The ca split area entering t urine from the blade during urination).	ion on 6/7/21, at 3:31 p.m. N)-B and nursing assistant s room to assist with getting nto his wheelchair. RN-B lifted lained that the split under the ion and R4 had some R4 had an approximate it under his penis from his neatus downward at the base atheter was visible inside the the urethral duct (transmits der to the exterior of the body					
	was in bed lying on drain bag was within onto R4's bed frame urinary catheter leg resident but was on the drainage bag. T indwelling urinary ca to R4's body but un lack of a securely p pulling of the indwe more pull on the ure	ion on 6/8/21, at 9:25 a.m. R4 his left side. R4's catheter n the privacy pouch attached e. R4's lower indwelling strap was not attached to n the catheter tubing line, near The second leg strap for the atheter tubing was unattached ider R4's left ankle area. The placed leg strap could result in elling urinary catheter causing ethra and could have further le skin irritation or erosion.					
	practitioner (NP)-A erosion at the base catheter use and sh	6/7/21, at 1:02 p.m. nurse stated R4 had penile urethral of his penis was caused from ne was unaware of this until fied her on 5/5/21. NP-A					

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DEPART CENTER	FORM	APPROVED 0938-0391					
STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	ING			C
		245365	B. WING			06/0	08/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	Y - MARIAN OF ST P	AUL LLC			00 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	assess R4's perinea site/penis as R4 wa (W/C) or was aslee she typically read pro- completed routine way mention in the prog- erosion prior to 5/5/ further stated R4 was saw each resident at on campus at the fa- week. NP-A stated contact the provider per day. NP-A stated facility nurses and r notifying providers way residents. NP-A stated updated her on R4's stated had the facilite R4's catheter insert timely of the penile urethral erosion mat During interview on practical nurse (LPN R4's foley catheter penile urethral eros she had updated the the documentation. documented she has penile urethral eros orders for urology c During interview on stated R4 was note erosion when RN-B cares, a few days a	been unable to visually al area or catheter insertion is usually up in his wheelchair p during rounds. NP-A stated rogress notes when she visits and had not seen any ress notes about the urethral (21 by the facility staff. NP-A as admitted 4/8/21, and she at least once a month but was acility at least three times per the facility staff had access to r when not onsite, 24 hours ed she had communicated to managers her expectation of with change in condition in ted an order for urology on 5/5/21, after staff had s penile urethral erosion. NP-A ity assessed and monitored ion site and updated NP-A urethral erosion, the penile by have been avoidable. 6/7/21, at 2:45 p.m. licensed N)-C stated she had changed on 5/2/21, and noted the ion. LPN-C stated she thought e NP but was unable to find LPN-C stated, on 5/5/21, she ad informed the NP of the ion and had received referral consult. 6/7/21, at 3:45 p.m. RN-B d to have the penile urethral e worked with R4 during peri fter his admission. RN-B	F 6	584			
		efinitely looked different and					

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		AND HUMAN SERVICES			FORM	07/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245365	B. WING			C 08/2021
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENIT	TY - MARIAN OF ST P	AUL LLC		200 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	meatus into the bas irritated. RN-B furth if she had charted of and had assumed if since R4 had urolog there was no active had verbally inform penile urethral eros remember who the stated several nurs verbalized their com her on different day retrospect she shout manager and the pu- urethral erosion immalso updated the nu- cleaning the site pro- had not updated the document in R4's p assessments conce erosion. During interview on member (FM)-A star regarding any issue erosion, until some informed that R4 wa due to penile urethr the previous facility with R4's prior to hil to COVID-19, the nicatheter onsite whill stated, R4 had not erosions communic facility prior to disch	the erosion beginning at the se of R4's penis and it looked her stated she could not recall on the penile urethral erosion it was at baseline for the R4, gy issues in the past and that be beeding. RN-B indicated she ed the night shift about the sion but was unable to night nurse was. RN-B also ing assistants had come and neerns about the catheter to vs. RN-B also stated in uld have notified the nurse rovider about the penile mediately and should have ursing assistant care sheets on operly. RN-B verified that she e provider and did not progress notes or skin erning the penile urethral time in May 2021 when he was as to be seen by a urologist ral erosion. FM-A also stated r had not mentioned any issues is discharge. Initially R4 went le at a previous facility; but due ourses had been changing the le at the previous facility. FM-A had any concerns about cated to him by the previous harge.	F 684			
	During interview on	i 6/7/21, at 4:40 p.m. FM-B				

		AND HUMAN SERVICES				FORM	07/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245365	B. WING				C 08/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENIT	TY - MARIAN OF ST P	AUL LLC			00 EARL STREET AINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Continued From par stated she had com current facility and o (which prevented put from the urethra) we catheter tubing look During telephone in LPN-D, who worked previously resided, discharged from the skin issues with his if resident had any sisten been documented a openings with his put LPN-D also verified catheter several tim or abnormalities. LF catheter was last ch previous facility and skin issues that we During interview on medication aide (TM with R4 within seve the facility and obset bottom and looked immediately verball and further stated of skin assessments. During interview on manager (RN)-G st previous facility R4	nge 17 ne to visit R4 while residing at observed catheter straps ulling of the foley catheter ere not in place and the ked dirty. nterview on 6/8/21, at 8:57 a.m. d at the facility where R4 stated when R4 was e previous facility he had no foley catheter. LPN-D stated skin conditions it would have and stated R4 had no enis while at their facility. I that she had changed R4's nes and noted no skin issues PN-D further stated R4's hanged on 4/5/21, at the d there was no indication of re identified in the documents. 6/8/21, at 11:15 a.m. trained MA)-A stated she had worked eral days after his admission to arved his penis was split at the different. TMA-A stated she by informed the nurse on duty, only the nurses completed the formed the nurse on duty, only the nurses completed the formed the nurse on duty, formed the nurse on duty, only the nurses completed the formed the nurse on duty, formed t	p	584			
	have any skin conc RN-G stated there current facility's adr identified penile ure	ous facility that R4 did not erns with his foley catheter. was no indication on the mission skin assessment that ethral erosion. RN-G also progress notes and skin					

Facility ID: 00354

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		AND HUMAN SERVICES				FORM	07/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245365	B. WING				C 08/2021
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENIT	TY - MARIAN OF ST P	AUL LLC			00 EARL STREET SAINT PAUL, MN 55106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ige 18	F 6	384			
		admission on 4/8/21 through umentation of R4's penile erosion.					
	director of nursing (informed that R4 po erosion upon admis documentation to s admission. DON sta that the admitting n assessment and do abnormal skin cond was also the expec nursing staff if a res erosion for continue	a 6/8/21, at 1:51 p.m. the (DON) stated she was ossibly had the penile urethral ssion; however, there was no how this was present on ated it was the expectation burse did a thorough skin ocumented findings of ditions in the resident's chart. It station that staff informed other sident had a penile urethral ed monitoring and to also the provider with this g.					
	Urinary Tract Infect indicated when a re- facility with a cathet physical assessment was to be complete Secured to avoid pu- bladder and urethra cleaned regularly w then rinsed. Staff w area of least contar	tion of Catheter-Associated tions Policy updated 12/29/17 esident was admitted to the ter in place, a thorough nt as well as history review ed. Catheter were to be ulling and trauma to the a. The peri-urethra was with mild soap and water and vere to always wash from the mination to the area of from front to the back.					
	resident examination capture any abnorm physical function, o This assessment w	nt Examination and undated, indicated a through on and assessment was to nalities in health status, or an acute change in condition. /as to provide the basis for the well as provide additional					

If continuation sheet Page 19 of 20

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245365	B. WING _				_ 08/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
CERENIT	Y - MARIAN OF ST P	AUL LLC		200 EARL STREET SAINT PAUL, MN 55106			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 684	and or refusals wer Electronic Health R The facility Prevent Breakdown Policy u is monitored, and a documented. Skin v cares. If any skin co to be reported to the	n as indicated. Physical exam e to be documented in the	F 68	34			

Facility ID: 00354

If continuation sheet Page 20 of 20



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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

Cerenity - Marian Of St Paul LLC July 1, 2021 Page 2

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: <u>susan.frericks@state.mn.us</u> 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:) 8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CERENI	TY - MARIAN OF ST P		-	06		
PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of will corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
	that may result fron orders provided tha the Department wit	n non-compliance with these t a written request is made to hin 15 days of receipt of a				
	On 6/3/21, through was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction y and identify the date	6/8/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 07/09/21

If continuation sheet 1 of 22

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМІ	E SURVEY PLETED
		00354	B. WING			C 08/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CERENII	TY - MARIAN OF ST P		L STREET AUL, MN 5510	16		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: H5365045C (MN73 orders issued at 02 Minnesota Departm the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far-le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a	4407; MN73192) with licensing 65 and 0830. Thent of Health is documenting Correction Orders using Tag numbers have been tota state statutes/rules for the assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is the To Comply" portion of r. This column also includes are in violation of the state				
	as evidence by." Fo findings are the Sug and Time Period fo You have agreed to	tement, "This Rule is not met ollowing the surveyor ' s ggested Method of Correction r Correction. • participate in the electronic nsure orders consistent with				
	the Minnesota Depa Informational Bullet https://www.health. n/infobulletins/ib14_ orders are delineate Department of Hea	artment of Health in 14-01, available at state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota Ith orders being submitted to				
	is necessary for Sta enter the word "CO available for text. Ye	Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the				
	heading completion be corrected prior to the Minnesota Depa	n date, the date your orders will o electronically submitting to artment of Health. The facility and therefore a signature is				
		bottom of the first page of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00354			COM	E SURVEY PLETED C 08/2021			
			TADDRESS, CITY, STATE, ZIP CODE						
IAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE					
ERENI	Y - MARIAN OF ST F	ΡΔΙΠ ΠΙΟ	L STREET AUL, MN 5510	06					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)			
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLET DATE			
2 000	Continued From pa	age 2	2 000						
	state form.								
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FED	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.							
2 265	MN Rule 4658.008 Resident Health St	5 Notification of Chg in atus	2 265			7/15/21			
	policies to guide st physicians, physici practitioners, and i legal representative member of a reside accident, or death. nursing services, a attending physician development of the	ust develop and implement aff decisions to consult an assistants, and nurse f known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an n must be involved in the ese policies. The policies must address at least the ation times for:							
		involving the resident which d has the potential for requiring ion;							
	physical, mental, o example, a deterio	t change in the resident's or psychosocial status, for ration in health, mental, or s in either life-threatening al complications;							
	example, a need to	Iter treatment significantly, for discontinue an existing form adverse consequences, or to of treatment;							

R47P11

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00354				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/08/2021	
	PROVIDER OR SUPPLIER		DDRESS. CITY.	STATE, ZIP CODE	1 00/0	0,2021
	Y - MARIAN OF ST P	200 FAR	L STREET	,		
	T - MARIAN OF ST F	AUL LLC SAINT P	AUL, MN 55	106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
2 265	Continued From pa	ge 3	2 265			
	D. a decision t resident from the n	o transfer or discharge the ursing home; or				
	E. expected an	d 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.		Corrected				
	Findings include:					
	hypertensive chron blood pressure cau stage 1 through sta (indicates advanced arteriosclerotic hea artery (blockage in cause heart attacks (severe pain in the the arms and neck) (systolic blood press millimeter of mercu manometric unit of	rt disease of native coronary the artery of the heart that can s) without angina pectoris chest, often also spreads to and orthostatic hypotension sure decrease of at least 20 ry (mm hg which is a pressure) or a diastolic blood of at least 10 mm Hg within				
	indicated R4 had se with diagnoses that irregular and often dysrhythmias (abno artery disease (dev	imum Data Set dated 4/14/21 evere cognitive impairment included atrial fibrillation (an rapid heart rate) or other ormal heart rhythms), coronary elops when the major blood your heart become damaged				

R47P11

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00354		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		C 06/08/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ERENI	TY - MARIAN OF ST F	ΡΔΙΠ ΠΙΟ	L STREET AUL, MN 5510	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	N SHOULD BE COMPLET E APPROPRIATE DATE	
2 265	Continued From page 4		2 265		,	
	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.		1			
	indicated amlodipin high blood pressur	ders Report dated 4/8/21, ne (medication used to treat e) 5 milligrams (mg), give one r at bedtime at 8:00 p.m.				
		lers Report dated 6/4/21, ne 5 mg tablet, give 10 mg t 8:00 p.m.				
		6:14 p.m. 9:16 p.m. 1:22 a.m.				
	- 4/10/21, 178/80 a - 4/10/21, 170/81 a - 4/11/21, 176/75 a - 4/13/21, 171/79 a - 4/14/21, 180/76 a	tt 4:50 a.m. tt 10:01 p.m. tt 04:36 a.m. tt 6:03 p.m.				
	- 4/15/21, 171/72 a - 4/16/21, 160/72 a - 4/17/21, 184/79 a - 4/25/21, 165/60 a	t 5:27 p.m. t 5:30 a.m. t 4:25 a.m. t 03:47 a.m.				
	- 5/8/21, 190/79 at - 5/8/21: 171/85 at - 5/22/21: 170/75 a epartment of Health	9:57 p.m.				

R47P11

If continuation sheet 5 of 22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 06/08/2021	
		00354				
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
		200 EAR	L STREET			
ERENII	TY - MARIAN OF ST F	AUL LLC SAINT P	AUL, MN 5510	6		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1		COMPLET DATE
				DEFICIENC	Y)	
2 265	Continued From page 5		2 265			
00	Communed From page 5					
	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		t			
	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.					
		he facility had not updated				
	providers when blo	od pressure readings were				
	abnormal.					
	During interview on	6/7/21 at 2:15 p.m. B4'a				
		n 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 dete	ermine the presence of				
		explained facility staff were to				
		g resident lay down and				
		sure using a manual blood as this was more accurate				
	•	blood pressure machine.				
		a resident had high blood				
		facility staff had a policy				
	regarding the range	e of BP that required				
	notification to the p	rovider. It was the expectation	1			

R47P11

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00254	B. WING		С	
		00354			06/	08/2021
	PROVIDER OR SUPPLIER	200 EAR	DRESS, CITY, ST L STREET	TATE, ZIP CODE		
CERENI	TY - MARIAN OF ST F	PAULIIC	AUL, MN 5510	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 6	2 265			
	were assessed with	ongoing high blood pressures h a high blood pressures and ified even when a resident was				
	medical aide (TMA routine vitals includ however, when the and nursing assista and they notified th readings were abno electronic medical results were entered	h 6/8/21, at 11:15 a.m. trained)-A stated nurses completed ling blood pressure checks; nurse was busy the TMA's ants (NA)'s would do the vitals he nurse immediately when the ormal. TMA-A also stated the record (EMAR) flagged after ed and alerted staff that the e out of normal range.				
	manager RN-G sta staff notified the pro- abnormal vitals sign abnormal blood pre- indicated that with 1 pressure above 160 should have update and the provider we make the determin the elevated results not document that rechecked when el- also lacked evident	n 6/8/21, at 11:54 a.m. nurse tited the expectation was that ovider immediately with ns including the elevated essure results. RN-B further R4's elevated systolic blood 0's mm hg, the nursing staff ed the provider immediately ould have been the one to ation on how to proceed with s. RN-B verified facility staff did R4's blood pressures were evated and R4's documents ce that the provider was a systolic blood pressures				
	director of nursing was noted to have pressure, the facilit recheck the "old fa manual blood press	n 6/8/21, at 1:51 p.m. the (DON) stated when a resident elevated abnormal blood ty staff were expected to shion" way and use the sure cuff as sometimes the essure machine could read				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00354	B. WING	B. WING		C 08/2021
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
ERENI	TY - MARIAN OF ST P	AULTIC	L STREET AUL, MN 5510	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	erroneous results. pressure readings of provider was not go needed to call the p stated the EMAR fla and alerted staff of Documentation that updated the provide pressures for R4, a high blood pressure immediately was re R1's admission Min identified R1 had a status (BIMS) of 14 cognitively intact. R assistance with beo and toileting. R1's Facesheet und that included hyper congestive heart fa (drop in blood press positioning), hypert insufficiency (poor F relating to a urinary Parkinson's disease R1's care plan date high blood pressure large drops in BP re treat hypertension (identified R1's syste 150 millimeters of r mmHg. Interventior signs and symptom	The DON stated if blood were consistently high, and the bing to be in house, staff provider. The DON further agged abnormal vitals results the abnormal range. t indicated the facility had er with elevated blood nd that elevated abnormally e levels were rechecked equested and not provided. himum Data Set (MDS) brief interview for mental out of 15, indicated R1 was 1 required extensive d mobility, transfers, dressing, dated, indicated diagnoses tension (high blood pressure), ilure, orthostatic hypotension sure with change in ensive urgency, renal kidney function), sepsis				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00054	B. WING		С	
		00354			06/	08/2021
IAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST . STREET	ATE, ZIP CODE		
ERENI	TY - MARIAN OF ST F	ΡΔΗ ΙΙΟ	UL, MN 5510	6		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TI DEFICIENCY		DATE
2 265	Continued From pa	age 8	2 265			
	R1 received three i	lers Report, undated, indicated medications to treat high blood HCl, hydralazine and losartain.				
	to 5/31/21, containe	re Vital Results dated 4/24/21, ed the following BP readings mentation of provider				
	- 4/24/21, 194/89 a - 4/30/21, 187/87 a - 5/1/21, 193/95 at - 5/2/21, 191/85 at - 5/4/21, 180/77 at - 5/4/21, 69/40 at 1	t 9:25 p.m. 4:20 a.m. 9:21 a.m. 7:22 a.m.				
	- 5/9/21, 183/80 at - 5/9/21, 188/84 at - 5/9/21, 190/82 at - 5/20/21, 180/91 a - 5/21/21, 190/97 a	8:47 p.m. 10:39 p.m. t 9:10 p.m. t 9:09 a.m.				
	 - 5/21/21, 208/88 a - 5/22/21, 199/74 a - 5/23/21, 182/84 a - 5/25/21, 180/81 a - 5/27/21,182/75 at - 5/27/21, 58/38 at - 5/29/21, 193/98 a 	t 8:32 p.m. t 7:19 a.m. t 11:39 p.m. : 8:13 a.m. 11:43 a.m.				
	- 5/31/21, 197/92 a	t 8:34 p.m.				
	licensed practical r resident's vital sign	on 6/4/21, at 10:16 a.m. hurse (LPN)-A stated if a is were abnormal she would titioner (NP)-A triage office to r.				
	described R1 as ha which ranged from	on 6/4/21, at 1:00 p.m. NP-A aving labile BPs (readings very high to very low). NP-A d R1's progress notes and BP				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			B. WING		С	
		00354			06/08/2021	
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
ERENI	ΓΥ - MARIAN OF ST F	PAULIIC	L STREET AUL, MN 5510	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 9	2 265			
	below 100 or above have notified her as required. She state a nurse manager a staff were aware of house standing ord	She stated if systolic BP was e 180 she expected staff would s interventions may have been ed she had discussed this with and many bedside nurses, and f the expectations relating to ders. 6/4/21, at 2:04 p.m. registered				
	abnormal she woul given PRN medica recheck the resider When interviewed assistant (NA)-A st When R1's BP was	d if a resident's BP was ld recheck it, give water, and tions if ordered. She would nt in 30 minutes to one hour. on 6/4/21, at 2:16 p.m. nursing ated R1's BP fluctuated often. s low she became fatigued and				
	she was stable, an When interviewed stated when she of would obtain a sec	bed, elevated R1's feet until d informed the nurse. on 6/4/21, at 2:42 p.m. NA-B otained a low BP reading she ond BP, asked the resident 3P was, encouraged water, and se.	1			
	stated she expecte obtained abnormal were standing hous to notify a provider or below 60. She tr PRN (as needed) r	on 6/6/21, at 3:29 p.m. RN-B ed the NAs to tell her if they BP readings. She stated there se orders which instructed staff if a systolic BP was above 140 reated the resident's BP with medications if ordered, one hour later, and updated	:			
	stated if an NA rep resident she check	on 6/6/21, at 3:40 p.m. RN-C orted an abnormal BP for a ed them again herself. If BP normal range she assessed				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		С		
		00354	B. WING		06/08/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
CERENITY - MARIAN OF ST PAUL LLC 200 EARL STREET SAINT PAUL, MN 55106							
(X4) ID	_	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 265	Continued From pa	age 10	2 265				
	and notified the pro- efficacy of the give resident had a syst would definitely cal resident, and docu When interviewed stated if BP reading them again. If they expected to tell the manually. If they w expected staff to n reviewed progress to locate documen	a PRN medication if ordered, ovider regardless of the n medication. She stated if a colic BP of 170 or higher she I the provider, monitor the ment a note in the record. on 6/6/21, at 3:54 p.m. RN-D gs were abnormal staff took were still abnormal staff were e nurse who would check them ere still abnormal RN-D otify the provider. RN-D notes for R1 and was unable tation of provider notification of abnormal BP readings.					
	physician (MD)-A s BP he would expect check and assess expected to be not below 70 systolic, a symptoms, or above presence of sympt	on 6/7/21, at 2:01 p.m. R1's tated if a resident had a high ct staff to perform a manual BF the resident. He stated he ified if the resident's BP was above 160 systolic with ve 180 regardless of the oms. He also stated that they supposed to document n.					
	The facility Standir requested and not	g House Order policy was provided.					
	directed staff to as resident's condition observation, intervistaff. Facility staff v provider of the cha implement orders f	e in Condition policy undated, sess significant change in the n noted through direct iew or report from the other were to notify the attending nge in condition and for treatment and appropriate cted. If staff were unable to					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:				
		00354	B. WING	B. WING		C 06/08/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
	TY - MARIAN OF ST F	ΡΔΗΓΕΙΟ	L STREET AUL, MN 5510	6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 265	Continued From pa	age 11	2 265				
	was to immediately with the resident re- significant change mental or psychoso the need to alter tre SUGGESTED MET administrator or de and implement poli catheter cares, skin monitoring and edu requirements. The assurance committa audits to ensure committa	appropriate. The community inform the resident, consults presentative when there was in the resident's physical, ocial status, or when there was eatment significantly. THOD OF CORRECTION: The signee could develop/revise icies and procedures related to n assessments, and vitals ucate staff on these quality assessment and tee could perform random ompliance. R CORRECTION: Twenty One					
2 830	Proper Nursing Ca Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t resident must rema prefers to remain in	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident	1			7/15/21	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00354	B. WING		C 06/08/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
CEDENI	TY - MARIAN OF ST F	200 EAR	L STREET			
CERENI	IT-WARIAN OF ST	SAINT P/	AUL, MN 55	106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	review, the facility facility for the catheter managem were completed to the penile urethral of body) for 1 of 3 m indwelling urinary of harm for R4.	tion, interview and document failed to ensure indwelling tent and skin assessments prevent erosion (tearing) of (opening for urine to pass out resident (R4), whom had an catheter. This caused actual		Corrected		
	Findings include:					
	diagnoses that incl dysfunction of blad loss of control of th obstructive and ref urine flow to the bla flow of urine flowin benign prostatic hy gland) with urinary kidney disease sta working well, causi	rinted 6/8/21, indicated uded neuromuscular der (a condition that results in ne bladder), unspecified lux uropathy (the obstruction of adder from the kidneys and the g backward into the kidneys), /perplasia (enlarged prostate tract symptoms, chronic ge 3 (when the kidneys are not ing swelling in hands and feet, nating more or less than				
	indicated R4 was a cognitive impairme two staff for toiletin	nimum Data Set dated 4/14/21, admitted in 4/21, had severe ent, required extensive assist of ig, bed mobility and transfers sessment triggered for urinary ndwelling catheter.				
	required an indwell that goes into the b in place) related to bladder control due nerve problem), wi interventions include	ed 4/9/21, indicated R4 ling urinary catheter (a tube bladder to empty it and remains neurogenic bladder (lack of e to a brain, spinal cord or th urinary retention and ded use of a catheter strap velling urinary catheter				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		IDENTIFICATION NOMBER.	A. BUILDING: _				
		00354	B. WING			C 06/08/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ERENIT	Y - MARIAN OF ST F	PAULIIC		_			
			AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 13	2 830				
	shift. Staff were to catheter monthly a	ocument urinary output every change the indwelling urinary nd as needed (PRN). Staff I the amount, type, color, odor akage.					
		ed 4/9/21, lacked monitoring R4's skin for se of the indwelling urinary					
	indicated to record output every shift; t urinary catheter ev	lers Report dated 4/8/21, indwelling urinary catheter to change the indwelling ery four weeks; and to use a nd night drainage bag when in					
		dy Audit: Skin Condition dated essment of any penile skin					
		dy Audit: Skin Condition dated sessment of any penile skin					
		essment with Braden Scale ked assessment of any penile					
	indicated R4's indw replaced, 16 Frence (cc) balloon with lig Resident tolerated but stated he was a place. Declined pa	es dated 5/2/21, at 2:11 p.m. velling urinary catheter th (Fr) 10 cubic centimeters ght yellow urine return. insertion with some discomford alright once catheter was in in medication. There was no hile skin irritation or erosion.	t				
	R4's Skin Risk Ass	essment with Braden Scale					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		BENNI IOMIONIBEN.	A. BUILDING:	A. BUILDING:		
		00354	B. WING			C 08/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	TY - MARIAN OF ST F	PALIE ELC.	L STREET			
		SAINT P	AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	dated 5/3/21, lacke skin irritation.	d assessment of any penile				
	indicated updated r appearance of mea- leading to the interi penis (tip of the per referral for indwellin concerns and evalu supra-pubic cathete R4's NP progress r 9:40 p.m. indicated concerns with the in They reported that seen farther down concern for further insertion site of the The note further in wheelchair on 5/5/2 examine his private	s dated 5/5/21, at 12:50 p.m. hurse practitioner (NP) on atus (a passage or opening for of the body) and glans his). Order received for urolog ng urinary catheter erosion uation for placement of er. hotes dated 5/5/21, printed at it nursing staff also expressed ndwelling urinary catheter . part of the catheter could be on his penis. There was opening or erosion around the indwelling urinary catheter. dicated R4 was seen in his 21, and the NP was unable to e areas. NP discussed with g to refer to urology for				
	schedule appointm urinary catheter erc for supra-pubic cat	ers dated 5/5/21, indicated ent with urology for indwelling osion concerns and evaluation heter (SP-catheter inserted the anterior abdominal wall).				
		ers dated 5/17/21, indicated esday 5/25/21, at 12:50 p.m. a	ıt			
	returned from urold orders for placeme	s dated 5/25/21, indicated R4 ogy appointment with new nt of a suprapubic (SP) y up appointment with urology				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY	
		BERTH TOXITOT TOMBER.	A. BUILDING: _	<u> </u>			
		00354	B. WING			C 06/08/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	TY - MARIAN OF ST F	PAULIIC	L STREET	_			
			AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 15	2 830				
	appointment on Th	ers dated 5/27/21, indicated an ursday 6/3/21, at 12:00 p.m. lacement at a local hospital					
	must be "nothing b	ers dated 6/8/21, indicated R4 y mouth" (NPO) after 5:00 a.m due to SP catheter placement					
	requested and not	ology appointments were provided by the facility. Severa te to interview the urologist	I				
	R4 was in dining ro indwelling urinary o visible below his let straps were hangin and not securing th	tion on 6/4/21, at 11:20 a.m. oom sitting at a table with his catheter drainage leg bag ft pants leg. R4's foley catheter ing loose around his left ankle he tubing to his leg causing the catheter on his penile					
	registered nurse (F (NA)-A entered R4' R4 out of bed and i R4's penis and exp penis was the eros reddened irritation. one-to-two-inch spl urethral down the r of his penis. The ca split area entering t	tion on 6/7/21, at 3:31 p.m. RN)-B and nursing assistant 's room to assist with getting into his wheelchair. RN-B lifted blained that the split under the ion and R4 had some R4 had an approximate lit under his penis from his neatus downward at the base atheter was visible inside the the urethral duct (transmits ider to the exterior of the body					
	was in bed lying on	tion on 6/8/21, at 9:25 a.m. R4 his left side. R4's catheter in the privacy pouch attached					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:	A. BUILDING: B. WING		C 06/08/2021	
		00354	B. WING				
AME OF PROVIDER OR SUPPLIER STREET A			DRESS, CITY, ST	ATE, ZIP CODE			
ERENIT	Y - MARIAN OF ST P		L STREET AUL, MN 5510	6			
X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	ige 16	2 830				
	onto R4's bed fram	e. R4's lower indwelling					
		strap was not attached to					
		the catheter tubing line, near					
		he second leg strap for the					
		atheter tubing was unattached					
		der R4's left ankle area. The					
		laced leg strap could result in ling urinary catheter causing					
		ethra and could have further					
		le skin irritation or erosion.					
		6/7/21, at 1:02 p.m. nurse					
		stated R4 had penile urethral					
		of his penis was caused from ne was unaware of this until					
		fied her on 5/5/21. NP-A					
		been unable to visually					
		al area or catheter insertion					
		as usually up in his wheelchair					
	,	p during rounds. NP-A stated					
		rogress notes when she					
		visits and had not seen any ress notes about the urethral					
		21 by the facility staff. NP-A					
		as admitted 4/8/21, and she					
		at least once a month but was					
		acility at least three times per					
		the facility staff had access to					
		r when not onsite, 24 hours					
		ed she had communicated to managers her expectation of					
		with change in condition in					
		ited an order for urology					
	consult was placed	on 5/5/21, after staff had					
		s penile urethral erosion. NP-A	N				
		ity assessed and monitored					
		tion site and updated NP-A					
		urethral erosion, the penile ay have been avoidable.					
		ay have been avoluable.					

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00354	B. WING		C 06/08/202 [,]
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
ERENI	Y - MARIAN OF ST F	2001 ΠΓΟ	L STREET AUL, MN 5510	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DAT
2 830	practical nurse (LP R4's foley catheter penile urethral eros she had updated th the documentation. documented she had penile urethral eros orders for urology of During interview or stated R4 was not erosion when RN-E cares, a few days a stated R4's penis d was unusual with th meatus into the bas irritated. RN-B furth if she had charted of and had assumed since R4 had urolo there was no active had verbally inform penile urethral eros remember who the stated several nurs verbalized their cor her on different day retrospect she sho manager and the p urethral erosion im also updated the nu cleaning the site pr had not updated th document in R4's p	n 6/7/21, at 2:45 p.m. licensed N)-C stated she had changed on 5/2/21, and noted the sion. LPN-C stated she though ne NP but was unable to find . LPN-C stated, on 5/5/21, she ad informed the NP of the sion and had received referral			
		n 6/7/21, at 4:28 p.m. family ated he had not been updated			

R47P11

If continuation sheet 18 of 22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00354		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 06/08/2021		
		200 FAR	L STREET	ATE, ZIF CODE		
	TY - MARIAN OF ST P	AUL LIC	AUL, MN 5510	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 18	2 830			
	erosion, until some informed that R4 w due to penile urethin the previous facility with R4's prior to hi to the urologist while to COVID-19, the m catheter onsite while stated, R4 had not erosions communic facility prior to disch During interview on stated she had com current facility and (which prevented p	es with R4's penile urethral time in May 2021 when he was as to be seen by a urologist ral erosion. FM-A also stated had not mentioned any issues s discharge. Initially R4 went le at a previous facility; but due urses had been changing the le at the previous facility. FM-A had any concerns about cated to him by the previous harge. 6/7/21, at 4:40 p.m. FM-B ne to visit R4 while residing at observed catheter straps ulling of the foley catheter rere not in place and the	9			
	LPN-D, who worked previously resided, discharged from the skin issues with his if resident had any been documented a openings with his p LPN-D also verified catheter several tim or abnormalities. LI catheter was last co previous facility and	ked dirty. Atterview on 6/8/21, at 8:57 a.m d at the facility where R4 stated when R4 was e previous facility he had no foley catheter. LPN-D stated skin conditions it would have and stated R4 had no enis while at their facility. I that she had changed R4's hes and noted no skin issues PN-D further stated R4's hanged on 4/5/21, at the d there was no indication of re identified in the documents.				
	medication aide (TI with R4 within seve the facility and obse	6/8/21, at 11:15 a.m. trained MA)-A stated she had worked ral days after his admission to erved his penis was split at the different. TMA-A stated she				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00354		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		B. WING		C 06/08/2021					
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE					
CERENITY - MARIAN OF ST PAUL LLC 200 EARL STREET SAINT PAUL, MN 55106									
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
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.								
	director of nursing informed that R4 p erosion upon admi- documentation to s admission. DON st that the admitting r assessment and do abnormal skin cond was also the expect nursing staff if a re erosion for continue	h 6/8/21, at 1:51 p.m. the (DON) stated she was ossibly had the penile urethral ssion; however, there was no show this was present on ated it was the expectation hurse did a thorough skin ocumented findings of ditions in the resident's chart. It ctation that staff informed other sident had a penile urethral ed monitoring and to also the provider with this g.							
	Urinary Tract Infect indicated when a re facility with a cathe physical assessme was to be complete Secured to avoid p	tion of Catheter-Associated tions Policy updated 12/29/17 esident was admitted to the ter in place, a thorough ent as well as history review ed. Catheter were to be ulling and trauma to the a. The peri-urethra was							

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
00354		B. WING		C 06/08/2021				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 FARI_STREET								
Y - MARIAN OF ST P	ΡΔΗ ΓΓΟ		_					
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
Continued From pa	age 20	2 830						
This assessment was to provide the basis for the initial care plan, as well as provide additional								
The facility Prevent Breakdown Policy of is monitored, and a documented. Skin cares. If any skin c to be reported to th	tion and Treatment of Skin undated indicated skin integrity abnormal findings were to be was to be observed daily with oncerns were noted, they were le licensed nurse. Weekly skin							
The director of nurse all residents with car abnormalities or en- receiving ongoing r the skin along with treatment/services providers are notified abnormalities or en- or designee, could delivery of care; rev- ensure appropriate implemented and r	sing or designee, could review atheter urethral skin issues, osions to assure they are monitoring and assessment of the necessary to prevent worsening and that ed of identified skin osions. The director of nursing conduct random audits of the view nursing assessments; to a care and services are educe the risk of these skin							
	OF CORRECTION PROVIDER OR SUPPLIER TY - MARIAN OF ST F SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From particles Continued From particles Continued From particles Continued From particles cleaned regularly withen rinsed. Staff wither area of least contar greatest and wipe for The facility Resident Assessment Policy resident examination capture any abnorm physical function, of This assessment within initial care plan, as updates to care plar and or refusals were Electronic Health F The facility Prevent Breakdown Policy of is monitored, and ard documented. Skin cares. If any skin c to be reported to the audits were to be p SUGGESTED MET The director of num- all residents with car abnormalities or er or designee, could delivery of care; re- ensure appropriate implemented and r	OF CORRECTION IDENTIFICATION NUMBER: 00354 00354 PROVIDER OR SUPPLIER STREET AI Y - MARIAN OF ST PAUL LLC 200 EAR SAINT P. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 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	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00354 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST Y- MARIAN OF ST PAUL LLC 200 EARL STREET SAINT PAUL, MN 5510 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 20 2 830 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. ID PREFIX TAG 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 p	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00354 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Y - MARIAN OF ST PAUL LLC 200 EARL STREET SAINT PAUL, MN 55106 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF C (EACH ORRECTIVE ACT (EACH ORRECTIVE ACT) Continued From page 20 2 830 2 830 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. PREFIX 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. The director of nursin	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00354 B. WING 06/ PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET SAINT PAUL, MN 55106 SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OBERCED TO IN SHOULD DE TAG Continued From page 20 2 830 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY Continued From page 20 2 830 Z 830 EXIMPLIAN OF ST PAUL LIC SUMMARY STATEMENT OF DEFICIENCY Continued From page 20 2 830 Z 830 Z 830 Continued From page 20 2 830 Z 830 Continued From page 20 Z			

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 06/08/2021			
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VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EARL STREET SAINT PAUL, MN 55106								
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2 830	Continued From page 21		2 830					
	(21) days.							
	epartment of Health							