DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 15, 2023

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

RE: CCN: 245365
Cycle Start Date: April 20, 2023

Dear Administrator:

On June 8, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 15, 2023

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

Re: Reinspection Results
Event ID: 9FV912

Dear Administrator:

On June 8, 2023 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 April 20, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2023

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

RE: CCN: 245365
Cycle Start Date: April 20, 2023

Dear Administrator:

On April 20, 2023, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 20, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 20, 2023 (six months after

the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	C 04/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/19/23, through 4/20/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53651447C (MN92711) with a deficiency issued at F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		5/16/23

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

Electronically Signed | 05/11/2023

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

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F 755	Continued From page 1 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system to reconcile controlled medications consistently and accurately was completed on 5 of 6 medications carts (5th floor carts 1 and 2, 4th floor carts 1 and 2, and 3rd floor cart 2) at the end of each shift. In addition, the facility failed to ensure appropriate destruction of discontinued controlled medications. This had the potential to affect all residents in the facility. Finding include: On 4/19/23, review of the controlled medications book count on 5th floor cart1 at 10:51 a.m. indicated trained medication aide (TMA-B) failed to sign the controlled medications book count after shift changed on 5th floor cart 1. TMA-B was interviewed at that time and stated she was busy	F 755	This credible Allegation of Compliance has been prepared and submitted timely. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

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F 755	Continued From page 2 helping one resident, so the night nurse counted and signed the controlled medications count book. TMA-B stated she should have asked somebody to count with her. On 4/19/23, at 12:34 p.m. a reviewed of the controlled medications book count on 5th floor cart one showed missing signature for the controlled medications counted on 4/14/23, night shift, 4/15/23, evening and night shifts, and 4/17/23, evening and night shifts, and on cart 2, night shift. On 4/19/23, at 2:30 p.m. registered nurse (RN)-D stated TMAs could receive the controlled medications from the pharmacy, and could destroy them with another nurse in the medication safe room after signing. On 4/19/23, at 2:40 p.m. RN-F stated the facility did not provid education about medication storage and destruction when he started working in the facility. RN-F further stated he relied on his previous experience about medication destruction, and did not know the process in the facility. On 4/19/23, at 3:00 p.m. the consultant pharmacist (P)-A was interviewed and stated he expected two licensed nurses, not TMAs, to destroy the controlled medications. P-A also stated stated the controlled medications book account should be verified by two nurses, and the count should be signed at the beginning and the end of a shift. On 4/20/23, at 10:15 a.m. during a reconciliation of the controlled medication with TMA-B on 5th floor cart 1, a blank space was noted on 2/3/23,	F 755	Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. The facility has a system to reconcile controlled medications consistently and accurately. On 4/20/2023 the nurse managers audited and reconciled the controlled medications for the noted 5 carts. The facility has a system in place to ensure appropriate destruction of discontinued controlled medications. All controlled medications are consistently and accurately reconciled at the end of each shift. All controlled medications are destroyed per policy. The facility reviewed, and revised, their policies on narcotic reconciliation and destruction. The facility provided education to all licensed nurses and Trained Medication Aides (TMA□s) on the new system. Two nurses are responsible for signing in newly delivered narcotics. Narcotics are counted at the end of each shift with either two nurses or a nurse and a TMA, and whenever keys are handed over. Two staff nurses are allowed to	

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F 755	Continued From page 3 page 56, with a sticky note for the nurse to sign but no follow up noted. TMA-B stated, "Someone didn't sign." When asked about the process to destroy the fentanyl patches (a narcotic controlled medication), TMA-B stated she destroyed one today after signing, and put in the safe with TMA-C. The facility policy Hazardous Waste Pharmaceuticals/Disposal dated 9/20/20, directed licensed nurses should place pharmaceutical waste within the drug enforcement administration (DEA) approved disposal receptacle or medication safe room in a designated area. The facility policy Individual Narcotic Record dated 2020, directed controlled medications should be counted with two nurses at shift change. R1's quarterly Minimum Data Set (MDS) dated 2/16/23, indicated R1 required hospice services, and narcotic pain medication for pain. The death in facility MDS indicated R1 was deceased 4/8/23. R1's orders dated 4/5/23, indicated buprenorphine transdermal patch (narcotic pain patch) 10 micrograms (mcg)/ hour (hr) apply to skin, apply once weekly, and orders buprenorphine transdermal patches 7.5 mcg/hr dated 3/29/23, discontinued 4/4/23, apply weekly on Wednesdays. On 4/19/23, at 10:25 a.m. licensed practical nurse (LPN)-A was interviewed and stated TMAs,	F 755	destroy a wasted narcotic or a used patch. Two nurses, one of which is a Nurse Manager, are present for the destruction of the discontinued narcotics and the destruction record is uploaded into the patient□s EMR. The nurse managers will audit conduct Controlled Substances Audits 3X□s per week for 4 weeks, then 2X□s per week for 4 weeks, and then 1X per week for 4 weeks. Any noted issue or discrepancy will be addressed. Audit results will be submitted to the facility□s QAPI committee for input/suggestions. The DON is responsible for ensuring that narcotics are reconciled consistently and properly at the end of each shift and that they are destroyed per policy.	

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F 755	Continued From page 4 nurses, nursing supervisors, and the director of nursing (DON) had keys to the medication storage room. LPN-A stated the facility policy and expectation was to count narcotics in the medication carts and medication storage rooms with two nursing staff which could include a TMA, at the end of each shift, and sign the Narcotic Count Book to indicate the counts were performed. LPN-A further stated there was a time when the counts were not correct, a supervisor was notified, and it was determined the missing medication was administered as an as needed (PRN) medication. LPN-A acknowledged the narcotic counts were not always completed as expected, and as demonstrated by omission of six of sixty expected signatures in the Narcotic Count Book from 4th floor medication cart 2, and omission of five of sixty expected signatures from 4th floor medication cart 1 from April 10, 2023, through April 19, 2023. On 4/19/23, at 11:01 a.m. LPN-B was interviewed and stated only nurses had keys to medication storage rooms, not TMAs, but TMAs were allowed to administer controlled substances, also known as Schedule II-IV medications or narcotics. LPN-B stated the index in the back of the Narcotic Count Book, which was stored in the locked medication cart, listed narcotic medications stored in the locked box in the medication cart or the locked refrigerator in the medication storage room that required counts every shift, with two nurses. LPN-B stated the nurse leaving each shift was expected to count the narcotics with the nurse arriving for the next shift, and both were expected to sign the Narcotic Count Book to indicate the count of each remaining narcotic was correct. LPN-B acknowledged the narcotics counts had not been	F 755		

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F 755	Continued From page 5 performed each shift in April as demonstrated by the omission of four of sixty expected signatures in the Narcotic Count Book from April 10, 2023, through April 19, 2023, in the Transitional Care Unit, medication cart 2 Narcotic Count Book. LPN-B further stated, even when nursing staff worked a double shift, the expectation was to perform the narcotic counts at the end of each shift. On 4/19/23, at 10:38 a.m. LPN-A was observed giving her keys for medication cart 2, which LPN-A acknowledged included the key to the narcotic lock box, to TMA-A without counting the narcotics in the medication cart. On 4/19/23, at 10:43 a.m. TMA-A was observed giving the medication cart keys back to LPN-A. On 4/19/23, at 12:08 p.m. LPN-A was interviewed and stated the process for narcotic destruction was to cross the medication off and sign their names to the corresponding medication listing in the Narcotic Count Book. Then, the nurse removed the narcotic from the cart with another nurse as a witness, completed the medication destruction form with the narcotic name, quantity, and date, both nurses signed the form, and finally took the medication together to the 5th floor and placed the narcotic into the locked medication safe for destruction. LPN-A further stated if another nurse was not available for the medication destruction process, the medication remained in the medication cart or refrigerator, and was counted with shift change counts until another nurse was available. LPN-A stated she was taught that process at the beginning of her third month of employment at the facility.	F 755		

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F 755	Continued From page 6 On 4/19/23, at 2:16 p.m. TMA-A was interviewed and stated if a nurse manager (NM) or director of nursing (DON) helped destroy a narcotic, the TMA could co-sign for narcotic destruction, but the TMA could not co-sign for another LPN or registered nurse (RN). TMA-A further stated TMAs and nurses could destroy used narcotic transdermal patches together. On 4/19/23, at 2:20 p.m. (RN)-B was interviewed and stated the destruction of narcotics required two nurses, not TMAs, and if another nurse was not available for narcotic destruction, the narcotic remained in the medication cart lock box or locked refrigerator until another nurse was available. RN-B stated that was the process at a previous employer, but had not received education about the process at this facility. On 4/19/23, at 3:04 p.m. RN-C was interviewed and stated two nurses were required to put narcotics in the medication safe, not one, even if the nurse was a NM or the DON. On 4/20/23, at 8:08 a.m. TMA-A was interviewed and stated she was the person who discovered the narcotic transdermal pain patches were missing on 4/12/23, and reported it to the supervisor. TMA-A stated if a resident was discharged or deceased, the process for a TMA to perform narcotic destruction was to reconcile the narcotics for that resident with the NM, both the TMA and NM signed the narcotic count sheet, and the NM took the narcotic to the medication safe for destruction alone as TMAs were not allowed to destroy narcotics. TMA-A stated that process was taught during the education she received after a similar incident in January 2023, but had received new information and education	F 755		

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F 755	Continued From page 7 on 4/19/23. TMA-A stated previously when a resident wore a transdermal pain patch, the TMA and nurse could remove the patch together, and dispose of the patch in a container on the NM's desk, but now the patches were disposed of by the NM in the medication safe. TMA-A further stated when passing keys back and forth during the shift, the process was for the nurse to give their medication cart keys to the TMA at 10:00 a.m. without counting the narcotics, but if the nurse needed the keys again, the TMA would give them back to the nurse, again without counting the narcotics. TMA-A acknowledged the key to the locked narcotic box was included in the set of keys that was passed back and forth, and stated she was concerned if narcotics were missing, she could be held responsible for them. On 4/20/23, at 8:22 a.m. LPN-A was interviewed and stated R1's buprenorphine transdermal patches were discovered missing on 4/12/23. LPN-A stated R1 had one box that contained three buprenorphine patches with a dose of 10 mcg/hr and another box of three buprenorphine patches, with a dose of 7.5 mcg/hr. LPN-A stated she put both boxes in the 4th floor medication storage room on 4/10/23, at approximately 7:00 a.m., where she thought she was supposed to put the boxed to be taken for destruction. LPN-A stated it appeared there were many different medications sitting on the counter at the time. LPN-A stated she counted the patches in the medication storage room again on 4/11/23, at approximately 12:00 p.m. as they had not yet been taken for destruction. On 4/12/23, LPN-A was working on another floor, but was contacted by TMA-A who asked LPN-A to come to the 4th floor as the medications stacked in the medication room looked different and messier	F 755		

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F 755	Continued From page 8	F 755		

than the previous two days, and the patches were no longer on the counter. LPN-A stated TMA-A then reported the six missing patches to the supervisor. LPN-A stated she was hired in January 2023, and did not receive training about destroying meds at the time, was not told narcotics in the medication storage room set on the counter required a double lock, but acknowledged narcotics stored in the medication cart and refrigerator required a double-lock to prevent diversion. Additionally, LPN-A stated she was not told to count the narcotics if staff was passing the keys back and forth during a shift. LPN-A stated the medication pass process during the morning shift when a nurse and a TMA worked together was the nurse passed medications from their own cart in the morning, and then gave the keys to the TMA to pass the remaining medications for the shift. LPN-A stated when they don't count narcotics when the keys are passed, it could become a problem for two staff instead of one, if narcotic counts are not accurate at the end of the shift.

On 4/20/23, at 8:35 a.m. RN-A was interviewed and stated when keys were exchanged between staff, the expectation was to count narcotics first, and if the key-holder left for a short break, the keys were not passed to another staff if a narcotic count was not performed. Additionally, RN-A stated narcotic destruction required two nurses, and two signatures, and TMAs were not allowed to count or destroy narcotics per the training she had in the previous week.

On 4/20/23, at 11:20 a.m. P-A was interviewed and stated the current medication count system was not designed to prevent diversion, but instead was designed to catch diversion after it

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	245365	A. BUILDING _____ B. WING _____	C 04/20/2023

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

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F 755	Continued From page 9 occurred. The pharmacist stated ideally two licensed personnel performed narcotic counts between shifts. On 4/20/23, at 11:57 a.m. the DON was interviewed and stated the expectation was the destruction of narcotics always required two nurses, and no TMAs. The DON did not know if the policy indicated narcotics were counted during the shift if keys were passed between staff, but further acknowledged staff could have to leave before the end of their shift and then the risk was missing narcotics if counts were not done with each key exchange. The DON further stated narcotic counts required two staff, nurses and/or TMAs, but one staff could not perform the counts alone, "That's not negotiable." She stated the process for missing narcotic counts between shifts was staff contacted the person who left without performing the count to come back to the facility, but did not know what the process was if the staff did not return for the count/signature, nor who was supposed to call staff to request they return. The process for a narcotic not signed out from the Narcotic Count Book after administration to a resident, was a sticky note added to the corresponding page in the book to remind staff to sign. Additionally, the DON stated pool staff (contracted staff who were not employees of the facility) received a two-hour orientation when their first shift at the facility, but did not know if that orientation included how to destroy narcotics. The DON also stated there was no resolution to the missing transdermal pain patches, but related staff questioned some of the behavior of one of the pool nurses, who would not be allowed to return. When asked how she knew if the education regarding narcotic destruction was effective and if she was aware TMAs still	F 755		

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F 755	Continued From page 10 destroyed transdermal pain patches together without a nurse on 4/20/23, the DON stated that should not happen and, "I don't know why. Oh Lord." The DON acknowledged two TMAs signed a narcotic destruction form on 4/20/23, and stated audits would continue.	F 755		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 9FV911

Dear Administrator:

The above facility was surveyed on April 19, 2023 through April 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: From 4/19/23, through 4/20/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H53651447C (MN92711) with a licensing order issued at MN Rule 4658.1350 Subp. 2 A.B. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by:	21630		5/16/23

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21630	Continued From page 3 Based on observation, interview, and document review, the facility failed to ensure a system to reconcile controlled medications consistently and accurately was completed on 5 of 6 medications carts (5th floor carts 1 and 2, 4th floor carts 1 and 2, and 3rd floor cart 2) at the end of each shift. In addition, the facility failed to ensure appropriate destruction of discontinued controlled medications. This had the potential to affect all residents in the facility. Finding include: On 4/19/23, review of the controlled medications book count on 5th floor cart1 at 10:51 a.m. indicated trained medication aide (TMA-B) failed to sign the controlled medications book count after shift changed on 5th floor cart 1. TMA-B was interviewed at that time and stated she was busy helping one resident, so the night nurse counted and signed the controlled medications count book. TMA-B stated she should have asked somebody to count with her. On 4/19/23, at 12:34 p.m. a reviewed of the controlled medications book count on 5th floor cart one showed missing signature for the controlled medications counted on 4/14/23, night shift, 4/15/23, evening and night shifts, and 4/17/23, evening and night shifts, and on cart 2, night shift. On 4/19/23, at 2:30 p.m. registered nurse (RN)-D stated TMAs could receive the controlled medications from the pharmacy, and could destroy them with another nurse in the medication safe room after signing. On 4/19/23, at 2:40 p.m. RN-F stated the facility did not provid education about medication	21630	CORRECTED	

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21630	Continued From page 4 storage and destruction when he started working in the facility. RN-F further stated he relied on his previous experience about medication destruction, and did not know the process in the facility. On 4/19/23, at 3:00 p.m. the consultant pharmacist (P)-A was interviewed and stated he expected two licensed nurses, not TMAs, to destroy the controlled medications. P-A also stated stated the controlled medications book account should be verified by two nurses, and the count should be signed at the beginning and the end of a shift. On 4/20/23, at 10:15 a.m. during a reconciliation of the controlled medication with TMA-B on 5th floor cart 1, a blank space was noted on 2/3/23, page 56, with a sticky note for the nurse to sign but no follow up noted. TMA-B stated, "Someone didn't sign." When asked about the process to destroy the fentanyl patches (a narcotic controlled medication), TMA-B stated she destroyed one today after signing, and put in the safe with TMA-C. The facility policy Hazardous Waste Pharmaceuticals/Disposal dated 9/20/20, directed licensed nurses should place pharmaceutical waste within the drug enforcement administration (DEA) approved disposal receptacle or medication safe room in a designated area. The facility policy Individual Narcotic Record dated 2020, directed controlled medications should be counted with two nurses at shift change. R1's quarterly Minimum Data Set (MDS) dated 2/16/23, indicated R1 required hospice services,	21630		

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21630	Continued From page 5 and narcotic pain medication for pain. The death in facility MDS indicated R1 was deceased 4/8/23. R1's orders dated 4/5/23, indicated buprenorphine transdermal patch (narcotic pain patch) 10 micrograms (mcg)/ hour (hr) apply to skin, apply once weekly, and orders buprenorphine transdermal patches 7.5 mcg/hr dated 3/29/23, discontinued 4/4/23, apply weekly on Wednesdays. On 4/19/23, at 10:25 a.m. licensed practical nurse (LPN)-A was interviewed and stated TMAs, nurses, nursing supervisors, and the director of nursing (DON) had keys to the medication storage room. LPN-A stated the facility policy and expectation was to count narcotics in the medication carts and medication storage rooms with two nursing staff which could include a TMA, at the end of each shift, and sign the Narcotic Count Book to indicate the counts were performed. LPN-A further stated there was a time when the counts were not correct, a supervisor was notified, and it was determined the missing medication was administered as an as needed (PRN) medication. LPN-A acknowledged the narcotic counts were not always completed as expected, and as demonstrated by omission of six of sixty expected signatures in the Narcotic Count Book from 4th floor medication cart 2, and omission of five of sixty expected signatures from 4th floor medication cart 1 from April 10, 2023, through April 19, 2023. On 4/19/23, at 11:01 a.m. LPN-B was interviewed and stated only nurses had keys to medication storage rooms, not TMAs, but TMAs were allowed to administer controlled substances, also known as Schedule II-IV medications or	21630		

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21630	Continued From page 6 narcotics. LPN-B stated the index in the back of the Narcotic Count Book, which was stored in the locked medication cart, listed narcotic medications stored in the locked box in the medication cart or the locked refrigerator in the medication storage room that required counts every shift, with two nurses. LPN-B stated the nurse leaving each shift was expected to count the narcotics with the nurse arriving for the next shift, and both were expected to sign the Narcotic Count Book to indicate the count of each remaining narcotic was correct. LPN-B acknowledged the narcotics counts had not been performed each shift in April as demonstrated by the omission of four of sixty expected signatures in the Narcotic Count Book from April 10, 2023, through April 19, 2023, in the Transitional Care Unit, medication cart 2 Narcotic Count Book. LPN-B further stated, even when nursing staff worked a double shift, the expectation was to perform the narcotic counts at the end of each shift. On 4/19/23, at 10:38 a.m. LPN-A was observed giving her keys for medication cart 2, which LPN-A acknowledged included the key to the narcotic lock box, to TMA-A without counting the narcotics in the medication cart. On 4/19/23, at 10:43 a.m. TMA-A was observed giving the medication cart keys back to LPN-A. On 4/19/23, at 12:08 p.m. LPN-A was interviewed and stated the process for narcotic destruction was to cross the medication off and sign their names to the corresponding medication listing in the Narcotic Count Book. Then, the nurse removed the narcotic from the cart with another nurse as a witness, completed the medication destruction form with the narcotic name, quantity,	21630		

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21630	Continued From page 7 and date, both nurses signed the form, and finally took the medication together to the 5th floor and placed the narcotic into the locked medication safe for destruction. LPN-A further stated if another nurse was not available for the medication destruction process, the medication remained in the medication cart or refrigerator, and was counted with shift change counts until another nurse was available. LPN-A stated she was taught that process at the beginning of her third month of employment at the facility. On 4/19/23, at 2:16 p.m. TMA-A was interviewed and stated if a nurse manager (NM) or director of nursing (DON) helped destroy a narcotic, the TMA could co-sign for narcotic destruction, but the TMA could not co-sign for another LPN or registered nurse (RN). TMA-A further stated TMAs and nurses could destroy used narcotic transdermal patches together. On 4/19/23, at 2:20 p.m. (RN)-B was interviewed and stated the destruction of narcotics required two nurses, not TMAs, and if another nurse was not available for narcotic destruction, the narcotic remained in the medication cart lock box or locked refrigerator until another nurse was available. RN-B stated that was the process at a previous employer, but had not received education about the process at this facility. On 4/19/23, at 3:04 p.m. RN-C was interviewed and stated two nurses were required to put narcotics in the medication safe, not one, even if the nurse was a NM or the DON. On 4/20/23, at 8:08 a.m. TMA-A was interviewed and stated she was the person who discovered the narcotic transdermal pain patches were missing on 4/12/23, and reported it to the	21630		

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21630	Continued From page 8 supervisor. TMA-A stated if a resident was discharged or deceased, the process for a TMA to perform narcotic destruction was to reconcile the narcotics for that resident with the NM, both the TMA and NM signed the narcotic count sheet, and the NM took the narcotic to the medication safe for destruction alone as TMAs were not allowed to destroy narcotics. TMA-A stated that process was taught during the education she received after a similar incident in January 2023, but had received new information and education on 4/19/23. TMA-A stated previously when a resident wore a transdermal pain patch, the TMA and nurse could remove the patch together, and dispose of the patch in a container on the NM's desk, but now the patches were disposed of by the NM in the medication safe. TMA-A further stated when passing keys back and forth during the shift, the process was for the nurse to give their medication cart keys to the TMA at 10:00 a.m. without counting the narcotics, but if the nurse needed the keys again, the TMA would give them back to the nurse, again without counting the narcotics. TMA-A acknowledged the key to the locked narcotic box was included in the set of keys that was passed back and forth, and stated she was concerned if narcotics were missing, she could be held responsible for them. On 4/20/23, at 8:22 a.m. LPN-A was interviewed and stated R1's buprenorphine transdermal patches were discovered missing on 4/12/23. LPN-A stated R1 had one box that contained three buprenorphine patches with a dose of 10 mcg/hr and another box of three buprenorphine patches, with a dose of 7.5 mcg/hr. LPN-A stated she put both boxes in the 4th floor medication storage room on 4/10/23, at approximately 7:00 a.m., where she thought she was supposed to put the boxed to be taken for destruction. LPN-A	21630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00354	A. BUILDING: _____ B. WING _____	04/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21630	Continued From page 9 stated it appeared there were many different medications sitting on the counter at the time. LPN-A stated she counted the patches in the medication storage room again on 4/11/23, at approximately 12:00 p.m. as they had not yet been taken for destruction. On 4/12/23, LPN-A was working on another floor, but was contacted by TMA-A who asked LPN-A to come to the 4th floor as the medications stacked in the medication room looked different and messier than the previous two days, and the patches were no longer on the counter. LPN-A stated TMA-A then reported the six missing patches to the supervisor. LPN-A stated she was hired in January 2023, and did not receive training about destroying meds at the time, was not told narcotics in the medication storage room set on the counter required a double lock, but acknowledged narcotics stored in the medication cart and refrigerator required a double-lock to prevent diversion. Additionally, LPN-A stated she was not told to count the narcotics if staff was passing the keys back and forth during a shift. LPN-A stated the medication pass process during the morning shift when a nurse and a TMA worked together was the nurse passed medications from their own cart in the morning, and then gave the keys to the TMA to pass the remaining medications for the shift. LPN-A stated when they don't count narcotics when the keys are passed, it could become a problem for two staff instead of one, if narcotic counts are not accurate at the end of the shift. On 4/20/23, at 8:35 a.m. RN-A was interviewed and stated when keys were exchanged between staff, the expectation was to count narcotics first, and if the key-holder left for a short break, the keys were not passed to another staff if a narcotic count was not performed. Additionally, RN-A	21630		

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21630	Continued From page 10 stated narcotic destruction required two nurses, and two signatures, and TMAs were not allowed to count or destroy narcotics per the training she had in the previous week. On 4/20/23, at 11:20 a.m. P-A was interviewed and stated the current medication count system was not designed to prevent diversion, but instead was designed to catch diversion after it occurred. The pharmacist stated ideally two licensed personnel performed narcotic counts between shifts. On 4/20/23, at 11:57 a.m. the DON was interviewed and stated the expectation was the destruction of narcotics always required two nurses, and no TMAs. The DON did not know if the policy indicated narcotics were counted during the shift if keys were passed between staff, but further acknowledged staff could have to leave before the end of their shift and then the risk was missing narcotics if counts were not done with each key exchange. The DON further stated narcotic counts required two staff, nurses and/or TMAs, but one staff could not perform the counts alone, "That's not negotiable." She stated the process for missing narcotic counts between shifts was staff contacted the person who left without performing the count to come back to the facility, but did not know what the process was if the staff did not return for the count/signature, nor who was supposed to call staff to request they return. The process for a narcotic not signed out from the Narcotic Count Book after administration to a resident, was a sticky note added to the corresponding page in the book to remind staff to sign. Additionally, the DON stated pool staff (contracted staff who were not employees of the facility) received a two-hour orientation when their first shift at the facility, but did not know if that	21630		

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21630	Continued From page 11 orientation included how to destroy narcotics. The DON also stated there was no resolution to the missing transdermal pain patches, but related staff questioned some of the behavior of one of the pool nurses, who would not be allowed to return. When asked how she knew if the education regarding narcotic destruction was effective and if she was aware TMAs still destroyed transdermal pain patches together without a nurse on 4/20/23, the DON stated that should not happen and, "I don't know why. Oh Lord." The DON acknowledged two TMAs signed a narcotic destruction form on 4/20/23, and stated audits would continue. SUGGESTED METHOD OF CORRECTION: The pharmacist and/or director of nursing (DON) could review, revise, or create policies and procedures for reconciliation, destruction and storage of medications. Nursing and medication aide staff should be educated to those changes. The pharmacist and/or DON could routinely audit for reconciliation, destruction and storage of medications to ensure compliance. The results of those audits could be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21630		