STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	07/31/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to notify the medical provider of a change in health status for 3 of 5 residents (R1, R2, R3) reviewed for notification of change. Findings include: R1's face sheet indicated [DIAGNOSES REDACTED]. R1's progress note dated 7/24/20, at 2:41 p.m., noted R1 spiked a temperature this morning of 100.4. R1 received scheduled [MEDICATION NAME] dose of 650 milligrams (mg) at 8:00 a.m. The medical record lacked documentation of notification to the provider. R1's temperature on 7/27/20, at 9:25 a.m. was 101.6. R1's progress note dated 7/27/20, at 10:32 a.m., by the Infection Preventionist, noted R1 was placed on droplet precautions and tested for COVID-19, due to fever. The medical record lacked documentation of notification to the provider. R1's progress note dated 7/27/20, at 10:41 a.m. noted R1 was very lethargic, not eating, and vital signs of blood pressure of 132/62, pulse of 66, respirations of 16, and oxygen saturation of 90% on room air. Medical physician was in to see R1 and ordered immediate labs. R1's progress note dated 7/27/20, at 12:27 p.m. noted R1's vital signs were blood pressure of 103/55, pulse of 69, temperature of 99.6, respirations of 18, and oxygen saturation of 86% on room air. R1 was very lethargic and weak. R1 was sent to the emergency room for fever and signs/symptoms [MEDICAL CONDITION]. During interview on 7/30/20, at 12:30 p.m. R1's nurse practitioner (NP)-A stated there were two residents at the facility who had spiked fevers and no one from the facility called NP-A; those residents subsequently tested positive for COVID. R1 spiked a fever last Friday, 7/24/20, and no one notified NP-A. R1 had respiratory issues and fever and NP-A's expectation was the provider should be notified. NP-A thought R1's hospitalization might have been preventable if R1 had been tested and treated on Friday, 7/24/20. NP-A was not contacted about R1's fever on 7/27/20. Per NP-A, the rounding physician found out when getting ready to enter the room while doing rounds. During interview on 7/31/20, at 10:00 a.m., Infection Preventionist (IP) stated the expectation for when a resident has a fever or symptoms of COVID, the staff would place the resident on droplet precautions and notify the provider. When asked about R1's fever and symptoms on 7/24/20, IP verified the staff should have placed R1 on droplet precautions and notified the provider. IP was absent 7/24/20-7/26/27. IP was present on 7/27/20 and placed R1 on droplet precautions. R2's quarterly Minimum Data Set ((MDS) dated [DATE], indicated intact cognition. R2 required supervision with bed mobility, transfers, and locomotion on unit. R2 required extensive assist with toileting and dressing and limited assist with hygiene. R2's [DIAGNOSES REDACTED]. R2 had received [MEDICAL TREATMENT]. R2's progress note (PN) dated 7/28/20, at 10:41 p.m. indicated R2's temperature at 8:30 p.m. was 100.3 degrees. Tylenol was given. Temperature taken again shortly before 10:00 p.m. and it was 100.2. R2 had complained of body aches. Building charge nurse notified. R2's PN dated 7/29/20, at 3:23 a.m. indicated the director of nursing (DON) had been updated at 11:00 p.m. and R2 had been placed on droplet precautions at that time. R2's PN dated 7/29/20, at 11:57 a.m. (recorded as late entry 7/30/20, at 11:58 a.m.) indicated R2 was swabbed for COVID-19 due to symptoms of fever and body aches. The medical record lacked documentation the medical provider was notified. During interview on 7/31/20, at 10:16 a.m. facility Medical Director (MD)-A stated in the event of any fever or change in resident health status, especially during this time of COVID-19 pandemic, the expectation is to notify the provider immediately. MD-A stated there is an opportunity to improve on the notification of change in status at this facility. During interview on 7/31/20, at 11:50 a.m. director of nursing (DON) stated the expectation would be to notify the provider right away in the event of a fever or change in condition. During interview on 7/31/20, at 12:30 p.m. registered nurse clinical manager (RN)-A confirmed the medical record lacked documentation the provider had been notified of R2's fever. RN-A stated had called the provider today (7/31/20) and the provider verified no notification about R2's symptoms. Facility policy titled Change in Condition, undated, indicated when a significant change in residents's physical, mental or psychosocial status is identified by the licensed nurse, or when there is a need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notifies the resident/resident representative. R3's face sheet indicated [DIAGNOSES REDACTED]. Provider order on 5/11/20, indicated daily weights and to call provider if weight increased by 3 pounds in 1 day or 5 pounds in 1 week. Vital sign record showed R3's weights were not recorded on the following dates: 5/28/20, 5/31/20, 6/1/20, 6/2/20, 6/3/20, 6/7/20, 6/8/20, 6/10/20, 6/12/20, 6/14/20, 6/18/20, 6/20/20, 6/21/20, 6/24/20, 6/26/20, 6/29/20, 7/1/20, 7/7/20, 7/8/20, 7/9/20, 7/10/20, 7/14/20, and 7/17/20. Vital sign record showed R3's weight increased by more than 3 pounds on the following dates: 5/11/20, 5/15/20, 7/18/20, 7/21/20, 7/26/20. R3's weight increased by more than 5 pounds between 7/20/20 and 7/27/20. The medical record lacked documentation of R3 refusal to be weighed and lacked documentation of the provider being notified. During interview on 7/29/20, at 3:00 p.m. nurse manager, registered nurse (RN)-D described the process of daily weights was for the nurse assistant to take the weight and report to the nurse. The nurse entered the weight in the medical record. If there was too much difference between the previous day's weight, the resident was reweighed. Only one weight was entered into the medical record. If the weight was more than 3 pounds in one day or over 5 pounds in one week, the expectation would be to call the provider. RN-D reviewed R3's medical record and verified the missing weights and the weight gain. RN-D said sometimes weights get missed on the weekends. During the medical record review, RN-D said they are inconsistent. During interview on 7/30/20, at 12:30 p.m. R3's provider, Nurse Practitioner (NP)-A stated the expectation is for staff to call the provider for a weight gain of over 3 pounds in 1 day or 5 pounds over a week. NP-A does not recall receiving any calls about R3's weight gain.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to appropriately implement preventive measures to prevent the spread of COVID-19. The facility failed to initiate transmission based precautions for potential symptoms of COVID-19 for 1 of 3 residents (R1) reviewed. In addition the facility failed to notify the transportation and receiving health care team of a resident's suspected COVID-19 status for 1 of 1 (R2) residents reviewed. The facility also failed to provide appropriate infection surveillance. This had the potential to affect all 84 residents who resided in the facility. Findings include: TRANSMISSION BASED PRECAUTIONS Current recommendations from the MDH Long Term Care (LTC) Toolkit dated 6/5/20, indicated all residents positive for fever or symptoms should be isolated, placed under Transmission-based Precautions, and tested for COVID-19. R1's face sheet indicated [DIAGNOSES REDACTED]. R1's progress note dated 7/24/20, at 02:41 p.m., noted R1 spiked a temperature that morning of 100.4. R1 received scheduled [MEDICATION NAME] dose of 650 milligrams (mg) at 8:00 a.m. R1 was in a room with roommate. The medical record lacked documentation of notification to the provider, implementation droplet precautions, or moving R1 to a private room or cohorting with another symptomatic resident. R1's

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

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) vital sign on 7/27/20, at 9:25 a.m. was 101.6. The medical record lacked documentation of notification of the provider or moving R1 to a private room or cohorting with another symptomatic resident. R1's progress note dated 7/27/20, at 10:32 a.m., by the Infection Preventionist, noted R1 was placed on droplet precautions and tested for COVID-19, due to fever. R1's progress note dated 7/27/20, at 10:41 a.m. noted R1 was very lethargic, not eating, and vital signs of blood pressure of 132/62, pulse of 66, respirations of 16, and oxygen saturation of 90% on room air. Medical physician was in to see R1 and ordered immediate labs. R1's progress note dated 7/27/20, at 12:27 p.m. noted R1's vital signs were blood pressure of 103/55, pulse of 69, temperature of 99.6, respirations of 18, and oxygen saturation of 86% on room air. R1 was very lethargic and weak. R1 was sent to the emergency room for fever and signs/symptoms [MEDICAL CONDITION]. During interview on 7/31/20, at 10:00 a.m., Infection Preventionist (IP) stated the expectation for when a Resident has a fever or symptoms of COVID, the staff would place the Resident on droplet precautions and notify the provider. IP verified staff did not need to get permission to place a symptomatic resident on droplet precautions. When asked about R1's fever and symptoms on 7/24/20, IP verified the staff should have placed R1 on droplet precautions and notified the provider. IP was absent 7/24/20-7/26/27. IP was present on 7/27/20 and placed R1 on droplet precautions. During interview on 7/31/20, at 10:16 a.m. facility Medical Director (MD)-A stated in the event of any fever or change in resident health status, especially during this time of COVID-19 pandemic, the expectation is to notify the provider immediately. MD-A stated the provider would look at the symptoms from all angles to determine a course of action. MD-A stated isolation precautions should be implemented immediately for residents with signs and symptoms of COVID-19 in order to help prevent spread. MD-A stated it would be difficult to determine if R1's hospitalization could have been prevented. MD-A stated R1 had been monitored the same as if they had been positive (screening each shift). MD-A stated if R1 was put on isolation precautions right away, however, could have reduced the risk to other staff and residents. RESIDENT TRANSPORT OUT OF FACILITY Current recommendations from the MDH Long Term Care (LTC) Toolkit dated 6/5/20, indicated special considerations should be given to residents who must leave the facility for medically necessary purposes (e.g., [MEDICAL TREATMENT]). The facility should develop a process to ensure communication about inter-facility transfer of residents with confirmed or suspected COVID-19. The facility should alert the receiving facility ahead of time if there is COVID-19 in the building. R2's quarterly Minimum Data Set ((MDS) dated [DATE], indicated intact cognition. R2's [DIAGNOSES REDACTED]. R2 had received [MEDICAL TREATMENT]. R2's Medication Administration Record [REDACTED]. Mark Y for current symptoms and report to registered nurse. The order lacked direction to notify transportation company and [MEDICAL TREATMENT] facility. R2's progress note (PN) dated 7/28/20, at 10:41 p.m. indicated R2's temperature at 8:30 p.m. was 100.3 degrees. Tylenol was given. Temperature taken again shortly before 10:00 p.m. and it was 100.2. R2 had complained of body aches. Building charge nurse notified. R2's PN dated 7/29/20, at 3:23 a.m. indicated the director of nursing (DON) had been updated at 11:00 p.m. and R2 had been placed on droplet precautions at that time. R2's PN dated 7/29/20, at 11:57 a.m. (recorded as late entry 7/30/20, at 11:58 a.m.) indicated R2 was swabbed for COVID-19 due to symptoms of fever and body aches. R2's PN dated 7/29/20, at 6:54 p.m. indicated R2 returned from [MEDICAL TREATMENT] with no new orders. The PN lacked documentation the transportation company or [MEDICAL TREATMENT] facility had been notified of R2's suspected COVID-19 status prior to R2's departure. On 7/30/20, at 4:00 p.m. Davita [MEDICAL TREATMENT] facility administrator (DD)-A stated R2 was a patient at this Davita [MEDICAL TREATMENT] clinic and had received [MEDICAL TREATMENT] on 7/29/20. DD-A stated Davita had not been notified of any confirmed or suspected COVID-19. On 7/31/20, at 11:49 a.m. the director of nursing (DON) indicated for a resident with confirmed or suspected COVID-19 the expectation would be to notify receiving health care teams. DON stated the nurse manager would be expected to do this or the nurse working on the floor. DON was unable to verify if notification occurred with R2's suspected COVID-19 status. On 7/31/20, at 12:07 p.m., the registered nurse clinical manager (RN)-A stated the nurse on duty fills out a pre-screening form and faxes it to [MEDICAL TREATMENT] prior to their departure. The nurse on duty would call the [MEDICAL TREATMENT] center to update them on a suspected or confirmed COVID-19 status in a resident. When asked why [MEDICAL TREATMENT] or transportation was not notified, RN-A was unable to comment. On 7/31/20, at 12:16 p.m. registered nurse (RN)-B stated would let the clinical manager know of any change in resident status related to COVID-19 and clinical manager would update [MEDICAL TREATMENT] and transportation. On 7/31/20, at 12:23 p.m. registered nurse (RN)-C stated if a resident had pending COVID-19 status, the infection control nurse would notify [MEDICAL TREATMENT] company. The corporate Benedictine Health Systems (BHS) document titled Checklist for a Resident with Confirmed or Person Under Investigation (PUI) COVID-19 (undated) directed staff to educate both community-based and consultant personnel (podiatry, hospice, dental) due to the fact that they often provide care in multiple communities and can be exposed to or serve as a source of pathogen transmission. The checklist lacked direction to notify receiving facilities such as [MEDICAL TREATMENT] or transportation providers. SURVEILLANCE The Infection Preventionist (IP) provided a Floor Map used to track infections. The Floor Map lacked information on type of organism or antibiotics used. The Floor Map showed COVID status of Residents who were tested (+ or -), type of infection (fungal), body site (skin, gastrointestinal, urine) or MERSA (sic). The IP provided a Precaution List used to track residents on precautions and residents and staff with COVID symptoms. The Precaution List lacked information on the type of organism, body location, or antibiotics being used. The Precaution List noted who was on contact isolation, droplet isolation, or who had symptoms of COVID. During interview on 7/31/20, at 10:00 a.m., when asked how IP conducted infection surveillance, IP used a Floor Map which was updated each the month. IP was unable to articulate how or when coding was changed if one resident was in a room part of the month and a different resident was placed in the same room who was not on similar precautions. IP was unable to articulate how specific infectious organisms were tracked nor how IP could identify trends of infections. During interview on 7/31/20, at 10:00 a.m., IP explained surveillance of infections and COVID testing was tracked on the daily Precautions List. IP verified specific organisms and antibiotics were not tracked on the Precautions list. IP noted when resident tested for COVID, they were entered into ESource, their occurrence reporting system and infection control program. If the test was negative, IP would update ESource. When asked, IP did not know how to trend numbers of positive cases over weeks or months to know if prevalence going up or down.