Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 25, 2025

Administrator
Presbyterian Homes Of Arden Hills
3220 LAKE JOHANNA BOULEVARD
ARDEN HILLS, MN 55112

RE: CCN: 245424

Cycle Start Date: August 21, 2025

Dear Administrator:

On November 13, 2025, the Minnesota Departments of Health and Public Safety 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

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November 25, 2025

Administrator
Presbyterian Homes Of Arden Hills
3220 LAKE JOHANNA BOULEVARD
ARDEN HILLS, MN 55112

Re: Reinspection Results
Event ID: 1D0E3F-H2

Dear Administrator:

On November 13, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 21, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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September 9, 2025

Administrator
Presbyterian Homes Of Arden Hills

3220 LAKE JOHANNA BOULEVARD
ARDEN HILLS, MN 55112

RE: CCN:245424
Cycle Start Date: August 21, 2025

Dear Administrator:

On August 21, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 November 21, 2025 (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 February 21, 2026 (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)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101

Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

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September 9, 2025

Administrator
Presbyterian Homes Of Arden Hills
3220 LAKE JOHANNA BOULEVARD
ARDEN HILLS, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: 1D0E3F-H1

Dear Administrator:

The above facility survey was completed on August 21, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Arden Hills	**3220 LAKE JOHANNA BOULEVARD , ARDEN HILLS, Minnesota, 55112**

(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
E0000	Initial Comments On 8/18/25 through 8/21/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 8/18/25 through 8/21/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54242384C (1130905), H54248667C (1130908), and H54242621C (2594335). NO deficiencies were cited. 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 substantial compliance with the regulations has been attained.	F0000		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F0641		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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F0641 SS = D	Continued from page 1 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a complete and accurate comprehensive nursing assessment and Minimum Data Set (MDS) oral status assessment was performed for 1 of 1 resident (R69) reviewed for dental status. R69's annual Minimum Data Set (MDS) dated 1/2/25, indicated R69 had severe cognitive impairment, substantial/maximal assistance for personal hygiene (excluding oral hygiene) and supervision or touching assistance for oral hygiene. The MDS further indicated rejection of care behavior not exhibited. R69's MDS indicated no "Obvious or likely cavity or broken natural teeth" and no "Inflamed or bleeding gums or loose natural teeth." R69's MDS section V indicated care area assessment (CAA) for dental care was not triggered. R69's diagnoses included dementia, anxiety, mood disorder, and generalized weakness.	F0641		

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Presbyterian Homes Of Arden Hills	3220 LAKE JOHANNA BOULEVARD , ARDEN HILLS, Minnesota, 55112

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F0641 SS = D	Continued from page 2 R69's quarterly MDS dated 4/1/25 indicated no "mouth or facial pain, discomfort or difficulty with chewing." R69's quarterly MDS dated 6/30/25, indicated no "mouth or facial pain, discomfort or difficulty with chewing." R69's care plan revised 1/25/24, indicated R69 had an ADL (activities of daily living) self -care deficit with intervention of "ORAL CARE: I have my own teeth: I require set up supervision BID [twice a day] and assist to finish as needed. Fluoride rinse." R69's care plan further indicated R69 had a potential oral/dental health problem and instructed staff to "Complete an oral assessment/observation on [R69] per policy…Provide mouth care as per ADL personal hygiene." R69's oral care task sheet last revised on 2/2/24, indicated, "Supervise resident with oral hygiene. Instruct fluoride rinse for 1 minute then expectorate." The task sheet indicated completion of this task twice a day in the 30 day lookback period. R69's dental consult assessment form dated 12/9/24, indicated, "Obvious or likely cavity or broken natural teeth" and "Inflamed or bleeding gums or loose natural teeth." The assessment further indicated, "Resident Needs Direct Staff Assistance" for daily oral care and recommended, "Toothbrushing each morning and evening, brush teeth and gums for approximately 2 minutes, as tolerated, using a soft toothbrush and fluoride toothpaste." R69's progress note dated 1/2/25 at 9:29 a.m., indicated, "…Oral/dental findings not within normal limits, any interventions and notifications [if applicable]…" with no new interventions identified. R69's dental consult note dated 1/15/24, indicated, "Obvious or likely cavity, inflamed natural teeth, maintains oral care independently and needs direct staff assistance. Toothbrushing BID." R69's comprehensive nursing data collection dated 12/31/24, indicated, "Oral examination results-check all that apply…a. Broken or loosely fitting full or partial denture [chipped, cracked, uncleanable, or loose] b. No natural teeth or tooth fragment[s] [edentulous] c. Abnormal mouth tissue… d. Obvious or likely cavity or broken natural teeth e. Inflamed or bleeding gums or loose natural teeth…f. Mouth or facial pain, discomfort or difficulty with chewing." All of the boxes were unchecked (no issues identified). R69's provider order dated 6/16/25, indicated referral	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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F0641 SS = D	Continued from page 3 for oral surgery for a tooth extraction. During observation and interview on 8/18/25 at 7:02 p.m., R69 had some missing and some discolored and decaying teeth. R69 stated sometimes her mouth hurt and could not remember if she had had any dental work done recently. During observation and interview on 8/19/25 at 1:27 p.m., R69 stated no one helped when she brushed her teeth, and she can do it on her own. R69 could not tell me if she brushed her teeth this morning. Her toothbrush appeared to be in the same position as it was the previous evening. During observation and interview on 8/20/25 at 10:07 a.m., R69 in her wheelchair in the common area. R69 stated she did not brush her teeth this morning and no one offered to assist. R69 stated on occasion someone will help or offer to help, but could not articulate how often. R69 stated she would not refuse assistance with oral care. During interview on 8/20/25 at 12:13 p.m., family member (FM)-B stated she did not think R69 experienced a lot of tooth or mouth pain currently, therefore, they had chosen to delay a recommended tooth extraction for now. FM-B stated the family did not want to put R69 through oral surgery and sedation unnecessarily. FM-B further stated she did not think R69 was capable of independent oral care, and she did not believe staff brushed R69's teeth twice a day but could not say for sure. During interview on 8/20/25 at 1:45 p.m., nursing assistant (NA)-A stated R69 needed help with showers weekly and chin hairs were removed on bath day. NA-A stated R69 required set up for brushing teeth and should be done every day and should encourage R69 to complete oral care. NA-A stated R69's oral care task was basically signing off that she was set up and encouraged to complete oral care. NA-A stated she would assist as needed. During interview on 8/20/25 at 1:58 p.m., registered nurse (RN)-B stated would expect staff to sign off tasks only if completed and to document any refusals appropriately. During follow up interview on 8/20/25 at 2:29 p.m., RN-B stated the floor nurse was responsible to complete the annual nursing comprehensive assessment. RN-B stated the assessment should accurately reflect the resident's status since the bedside assessments drive	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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F0641 SS = D	Continued from page 4 the MDS assessments. RN-B further stated R69's comprehensive assessment was not completed appropriately which would affect the accuracy of the MDS, care plan and potentially the care she received. During interview on 8/20/25 at 2:34 p.m., director of nursing (DON) stated expectation for nurses to accurately assess residents and complete the bedside assessments timely and completely. DON further stated the bedside assessments drive MDS coding which drive care plan revisions and could affect the care a resident received. Facility policy Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission dated March 2025, indicated the facility interdisciplinary team would work together by completing assigned assessments. Accurate assessments require collecting data via multiple sources including evaluation of the resident, along with input from the resident, the resident's physician, family and direct care staff on all shifts. Further, the assessment should include date from the resident's medical record. The facility policy further indicated the Care Area Assessment [CAA] process is "designed to assist the assessor to systematically interpret the information recorded on the MDS. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the team and resident." The policy continues, the "care plan is an interdisciplinary communication tool. It describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being."	F0641		
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of	F0676		

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F0676 SS = D	Continued from page 5 this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure a comprehensive bladder assessment was completed and toileting program established for one of one residents (R7) reviewed for bladder continence. Findings include: R7's admission MDS dated 7/13/25, indicated R7 had cognitive impairment and diagnoses of hemiplegia (weakness on one side of the body) from a cerebral hemorrhage (brain bleed). R7's Bowel, Bladder and Skin Risk assessment dated 7/11/25, indicated R7 had a foley catheter and was continent of bowel and bladder prior to their cerebral hemorrhage. R7's Bowel, Bladder and Skin Risk assessment dated 7/30/25, indicated R7's foley had been removed and R7	F0676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0676 SS = D	Continued from page 6 had functional incontinence (incontinence due to a decrease in mental or physical abilities) with no voiding patterns. R7's quarterly Bowel, Bladder and Skin Risk assessment dated 8/4/25, indicated R7 had no bladder elimination patterns and had functional incontinence. R7 can identify the urge to void and was able to use the call light for assistance. R7's Bowel, Bladder and Skin Risk assessment dated 8/11/25, indicated R7's skin assessment however, lacked any bowel or bladder assessment. R7's IDT communication dated 8/13/25, indicated R7 was ablet to be transferred with a stand lift and 2 nursing staff members. R7's medical record lacked indication R7 had been assessed for bladder continence after being able to transfer with nursing staff. R7's care plan dated 7/13/25, indicated R7 required toileting every 2 hours and as needed. When interviewed on 8/18/25 at 1:47 a.m., R7 stated she was frustrated with not being able to use the toilet. R7 stated she was aware of when needing to void, but there was often delays with staff needing a second person and often was not able to wait any longer and would void in their brief. Furthermore, R7 stated staff informed her it was policy for residents to void in the brief and then get cleaned up. If R7 needed to have a bowel movement, then staff would help them into the bathroom. R7 stated they "just don't want to do that…voiding in my pants doesn't make me feel very good". When interviewed on 8/21/25 at 9:27 a.m., nursing assistant (NA)-D stated R7 was moving much better than when they were initially admitted and was able to use the call light and make their needs known. NA-D further stated R7 would call when needing the bathroom but was usually incontinent. R7 required a stand lift to assist in transferring to the wheelchair or the bathroom. When interviewed on 8/21/25 at 9:37 a.m., registered nurse (RN)-C stated when a resident was admitted, their bladder function was assessed. A bladder re-assessment was then completed if there were any changes. When residents were alert and able to ask to use the bathroom, we would offer a brief if they were ok with it just in case. This was especially for those with mobility issues, and it may take longer to get them up.	F0676		

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F0676 SS = D	Continued from page 7 RN-C stated if a resident was able to use the toilet, staff should be getting them up. If a resident was on a toileting program, it would be included on the care plan. RN-C stated R7 would use the call light when needing to use the bathroom, however, was not on a toileting program yet as mobility was just starting to improve. RN-C acknowledged an assessment should have been completed with her improvement in mobility, but did not see one completed. When interviewed on 8/21/25 at 9:48 a.m., occupational therapist (OT)-A stated therapy recommends how residents would transfer and stated R7's transfer status had been updated a week or two ago. R7 was able to use the stand lift with an assist of one nursing staff member and should be able to use the toilet if wanted to. When interviewed on 8/21/25 at 9:56 a.m., RN-A stated a bladder assessment was completed upon admission and then with any changes like a foley being removed, or mobility changes. RN-A acknowledged R7 did not have an updated assessment completed after their mobility was upgraded from therapy. When interviewed on 8/21/25 at 12:03 p.m., the Director of Nursing (DON) expected staff to complete a bladder assessment to be done when a catheter was removed and when transfer assessments were upgraded from therapy. The DON further stated this was important to ensure the care plan was individualized to the resident and work to have them function normally if they were able to. A facility policy titled Bowel and Bladder Assessment Policy revised 9/2018, directed staff to screen residents upon admission and with change in condition- an individualized toileting care plan will then be implemented.	F0676		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they	F0686		

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F0686 SS = D	Continued from page 8 were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure interventions were implemented for 1 of 2 residents (R44) reviewed for pressure ulcers. Findings include: R44's quarterly Minimum Data Set (MDS) dated 6/24/25, indicated R44 was cognitively impaired and had diagnoses of chronic respiratory failure and heart failure. R44 was dependent on staff for dressing and bed mobility. Furthermore, R44 had a stage 2 pressure ulcer. R44's pressure injury care area assessment dated 9/26/24, indicated R44 was at risk for pressure injury related to incontinence and decreased mobility. R44's bowel, bladder and skin risk assessment dated 6/24/25, indicated R44 was at mild risk for skin breakdown related to pressure and incontinence. Interventions included heel suspension/protective devices. R44's skin and wound evaluation dated 8/13/25, indicated R44 had a stage 2 right heel pressure injury that was identified on 6/25/25. R44 R44's provider and nursing orders indicated: -on 12/20/24, R44 required blue boots to booth heels (heel protectors) when up in wheelchair every day and evening shift. -on 3/19/25, R44 required right calf elevation to float right heel with a pillow. -on 4/8/25, R44 required assistance with placing pillows to offload feet from pressing the bottom of the padded foot box on the wheelchair and to offload heels and keep feet separated. R44's nursing assistant care sheet for the time of survey was requested however was not provided.	F0686		

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F0686 SS = D	Continued from page 9 R44's care plan revised 10/10/24, indicated R44 was at risk for impaired skin integrity related to incontinence, edema, and decreased mobility. R44 had a history of open area on right heel and was prone to bruising. Interventions included a pressure reducing bed and wheelchair cushion and staff repositioning upon waking, after breakfast and lunch, before supper, at bedtime and as needed. R44's care plan lacked indication R44 required heel elevation as indicated in the orders. An observation on 8/18/25 at 12:21 p.m., R44 was being wheeled out of their room to lunch. R44's wheelchair had a padded support on the legs of the wheelchair. R44's right leg was internally twisted and was rubbing against the other foot and R44's heels were resting on the supportive legs. R44 had no pillows or devices to elevate her heels. An observation on 8/19/25 at 8:49 a.m., R44 was in her room sitting up in their wheelchair. R44's heels were resting on the wheelchair support box and were not elevated with pillows or other devices. An observation on 8/20/25 at 6:44 a.m., trained medication assistant (TMA)-A entered R44's room to administer medication. R44 was laying on her back in bed. R44's legs were covered, and had pillows placed under their knees, pushing the knees up in the air. TMA-A raised the head of bed and administered R44'smedications. TMA left without ensuring R44's heels were not resting on the mattress. An observation on 8/20/25 at 7:58 a.m., nursing assistant (NA)-B entered R44's room and offer to get up for the day. R44 stated she was tired and wanted to sleep. NA-B stated they would return on a while and left without ensuring R44's heels were elevated off the bed. An observation on 8/20/25 at 9:53 a.m., R44's call light was answered by NA-C. R44 stated they were ready to get up for the day. NA-C pulled back the blankets and R44 had no blue boots in place and had pillows tucked underneath both knees. R44's heels were sitting on the bed. R44 complained of pain in the right middle part of the foot. R44's heel has no dressings in place and no open wound was seen. NA-C requested licensed practical nurse (LPN)- A to assess the foot. R44 requested pain medications and LPN-A left to obtain them. NA-B then entered to assist NA-C to transfer R44 via full lift. R44 was lifted in their wheelchair. R44 was not offered blue boots or heel elevation with pillows before brought out to breakfast.	F0686		

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F0686 SS = D	Continued from page 10 When interviewed on 8/20/25 at 10:33 a.m., NA-C stated R44 required assistance with dressing, transferring and repositioning but was independent with eating. NA-C stated sometimes R44 did not want to get up until later in the day and it could be different each day. NA-B verified R44's heels were resting on the bed at the start of cares and did not have heels elevated or blue boots in place. NA-B further acknowledged R44 did not have heels off loaded when up in the wheelchair. Hospice had gotten the foot box for R44 but was not aware of needing to elevate R44's heels. NA-C stated it had been a while since the resident had worn blue heel boots and that was taken off the care sheet a long time ago. NA-C pulled out the care sheet and verified there was no mention of blue boots when and how to keep them on or the need to elevate heels when in bed or in the chair. When interviewed on 8/20/25 at 10:40 a.m., licensed practical nurse (LPN)-A stated R44 had a heel pressure wound that had just resolved and was at risk of further pressure injuries. R44 had recently received the foot box and that was better for their feet than the pedals. LPN-A verified R44 still used the blue boots and the aides should be putting them on. Furthermore, LPN-A stated R44's heels should be elevated in bed and when in the chair. When interviewed on 8/21/25 at 9:56 a.m., registered nurse (RN)-A stated R44's heel wound had just resolved. Staff were expected to follow orders and interventions to help prevent any further pressure wounds from developing. When interviewed on 8/21/25 at 12:01 p.m., the Director of Nursing (DON) expected staff to follow orders and any determined interventions for the resident. If a resident was refusing the interventions, that would be documented. This was important to prevent any further wounds. A facility policy titled Skin Integrity Management Policy revised 10/2022, directed staff to implement preventative measures and provide appropriate treatment according to standards of care.	F0686		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection	F0880		

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F0880 SS = D	Continued from page 11 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880		

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F0880 SS = D	Continued from page 12 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure hand hygiene was completed for 2 of 3 residents (R7, R44) observed for personal cares. Furthermore, the facility failed to ensure shared mobility equipment was cleaned in between resident use. Findings include: R44's quarterly Minimum Data Set (MDS) dated 6/24/25, indicated R44 was cognitively impaired and had diagnoses of chronic respiratory failure and heart failure. R44 was dependent on staff for dressing and bed mobility. Furthermore, R44 had a stage 2 pressure ulcer. An observation on 8/20/25 at 9:53 a.m., R44's call light was answered by nursing assistant (NA)-C. R44's door had a sign that read enhanced barrier precautions (EBP)and instructed staff to gown and glove when providing close contact cares. R44 stated they were ready to get up for the day. After gathering supplies, NA-C performed hand hygiene and donned a gown and gloves. NA-C assisted R44 with upper body dressing and placed tubi-grips on feet. NA-B entered R44's room in a gown and gloves to assist with R44's brief change. NA-C removed the front of the brief and tucked down. R44's front side was cleaned by NA-C before NA-B assisted R44 to turn. NA-C then finished cleaning R44 from the back, tucked and removed the urine soaked brief and placed in the garbage. NA-C then opened a clean brief and set on the bed. NA-C removed gloves and without hand hygiene	F0880		

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F0880 SS = D	Continued from page 13 placed new gloves and placed the clean brief under R44. NA-B and NA-C continued to get R44 dressed and transferred to the wheelchair for breakfast. When interviewed on 8/20/25 at 10:33 a.m., NA-C verified hand hygiene was not completed after removing soiled gloves and before placing new ones. NA-C stated it was hard in the moment to do that when in the middle of the work and trying to get the resident finished and transferred. R7's admission MDS dated 7/13/25, indicated R7 had cognitive impairment and diagnoses of hemiplegia (weakness on one side of the body) from a cerebral hemorrhage (brain bleed). R7 required tube feeding for nutritional needs. R76's quarterly MDS dated 5/13/25, indicated R76 had cognitive impairment and diagnoses of heart failure. R76 required substantial assistance for transfers and toileting. An observation on 8/21/25 at 8:46 p.m., Occupational therapist (OT)-A entered R7's room for treatment. R7's door had a sign that indicated R7 required EBP and instructed staff to use a gown and gloves with close contact cares. OT-A was going to assist R7 with a morning bathroom routine. After bringing in a stand lift, OT-A performed hand hygiene and donned gown and gloves. OT-A then assisted R7 to the toilet with the stand lift. R7 used their hands to grab the bars of the stand lift during transfer. Once over the toilet, OT-A removed R7's soiled brief and lowered R7 to the toilet. OT-A then removed gloves and without hand hygiene, donned clean gloves. R7 was finished and then physical therapist (PT)-A entered the room to co-treat. R7 was then lifted back into the standing position an OT-A cleaned R7, changed gloves and without hand hygiene, placed new ones before placing a new brief on R7. PT-A and OT-A assisted R7 using the stand lift into the wheelchair, R7 had grabbed the stand lift to hold on during transport. Without cleaning the stand lift, OT-A pushed it out into the hall. OT-A then removed gown and gloves, performed hand hygiene and escorted R7 down to therapy without cleaning the stand lift used to assist R7. At 9:13 a.m., trained medication assistant (TMA)-A and NA-C wheeled the stand lift just used for R7 into R349's room. At 9:19 a.m., walked out of the room without the lift. AT 9:25 a.m., NA-C exited R76's room with the lift and cleaned it before leaving it in the hallway. When interviewed on 8/21/25 at 9:27 a.m., NA-C verified the lift taken into R76's room was not cleaned before	F0880		

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F0880 SS = D	Continued from page 14 use. Furthermore, NA-C stated lifts were cleaned after each resident use when placed in the hallway. When interviewed on 8/21/25 at 9:48 a.m., OT-A verified they had not performed hand hygiene with glove exchanges and had not cleaned the stand lift after R7's use. OT-A stated there was no hand sanitizer in the bathroom and she didn't want R7 to be in the stand lift too long but should have washed after glove removal. OT-A wasn't sure of the process of cleaning the lifts and believed once in the hallways, nursing staff wiped them down. When interviewed on 8/21/25 at 9:56 a.m., registered nurse (RN)-A stated lift equipment should be wiped down after each resident use. Whenever removing gloves, staff should be washing their hands or using hand sanitizer. When interviewed on 8/21/25 at 12:01 p.m., the Director of Nursing (DON) expected hand hygiene to be completed with each glove exchange and lift equipment to be sanitized after each resident use. A hospital policy titled Infection Control, Hand Hygiene revised 2020, directed staff to perform hand hygiene after removing personal protective equipment (PPE, gowns, gloves, etc) and before donning PPE. A facility policy titled Mechanical Lift Cleaning Policy dated 7/2018, directed staff to clean the lifts between residents when the resident has an infectious disease, or the resident touched the lift.	F0880		
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure a maintenance work order was followed up on timely for a resident who required padding at the dining table (R123). R123's Medical Diagnosis form indicated the following diagnoses: Parkinson's disease with dyskinesia (involuntary movements), muscle weakness, and pain in	F0921		

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F0921 SS = D	Continued from page 15 left shoulder. R123's Optional State Assessment (OSA) dated 7/17/25, indicated intact cognition, required extensive assistance with bed mobility, transfers, eating, and toilet use. R123's quarterly Minimum Data Set (MDS) dated 7/17/25, indicated R123 had impairment on one side of his upper body extremities, and used a wheelchair. R123's care plan dated 7/29/25, indicated R123 had a self-care deficit and required assistance to and from meals. R123's care plan dated 7/29/25, indicated R123 had limited physical mobility due to Parkinson's disease, left should and left knee pain, and used a wheelchair with assist of one to propel to all destinations. R123's progress notes dated 8/12/25 at 9:26 p.m., indicated R123 had a bruise and skin tear to his right forearm and R123 stated his arm was caught in between the dining room table and his wheelchair. R123's progress note dated 8/19/25 at 9:39 a.m., indicated R123 sustained a skin tear to the top of his left hand and bumped his hand on the dining table and a TELS order was placed for padding to his spot at the dining table. R123's progress note dated 8/19/25 at 10:04 a.m., indicated R123 had a skin tear to the right arm and bruises to the left arm and interventions based on the root cause analysis indicated to use caution when wheeling resident up to the dining table. R123's progress note dated 8/19/25 at 10:17 a.m., indicated R123 got his right arm caught between the wheelchair and the dining room table and a TELS was placed for padding at the table. The facility open TELS report dated 8/13/25 at 2:59 p.m., indicated a work order was placed requesting padding on table number 9 on the third-floor dining room. During interview and observation on 8/18/25 at 3:59 p.m., R123 was sitting in his recliner and family member (FM)-A stated R123 could not respond quickly when getting pushed up to the dining room table and bumped into the table. During observation on 8/20/25 between 12:11 p.m., and	F0921		

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F0921 SS = D	Continued from page 16 12:27 p.m., staff knocked on R123's door and entered his room. At 12:26 p.m., an unidentified staff person pushed R123 out to the dining room in his wheelchair. R123 was brought to the dining room table, table number 9, and his hands were resting on his knees. The staff person moved the chair out and brought R123 to the table and R123 placed his hands on the table and the staff person moved R123 closer to the table without striking R123's hands. During observation on 8/20/25 at 2:11 p.m., R123's table did not have any padding. During interview on 8/20/25 at 2:13 p.m., licensed practical nurse (LPN)-A stated R123 sat at table number 9. LPN-A stated when a TELS work order was placed, they received a response immediately or the same day. During interview on 8/21/25 at 9:29 a.m., environmental services director (ESD)-A stated when a work order was submitted, it had a priority of low, medium, or high and critical. ESD-A stated most work orders were a medium priority and further stated there was not a specific time requirement for completing work orders and was based on judgment. ESD-A further stated there were a lot of medium priority work orders and a lot of them were done the same day and some are not completed that day or even that same week. ESD-A stated their lead engineer recently retired. ESD-A stated the padding for the tables was for residents who bumped their hands and therapy came up with the idea to apply padding. ESD-A stated the work order was placed by registered nurse (RN)-A and further stated they were out of the padding and asked engineer technician (ET)-B if the padding was ordered and ET-B stated he forgot to order the padding 8/20/25, and would do it today. During interview on 8/21/25 at 9:48 a.m., registered nurse (RN)-A stated she followed up on falls and skin issues and stated R123 required the table padding because his hands get caught on the edge of the table when going out to eat and obtained skin tears and bruises. RN-A stated she spoke with environmental services, and they had to order the padding and was not sure how long work orders took to be completed but stated they could prioritize whether the request was low, medium, or high. RN-A stated priority was usually sent as a medium and added it was urgent to have the padding on the table to prevent any bruises or skin tears and would have expected the work order to have been completed by now. Household coordinator verified R123 sat at the first table on the left when entering the dining room from their office which was also table number 9.	F0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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F0921 SS = D	Continued from page 17 During interview on 8/21/25 at 10:23 a.m., the administrator stated staff can submit a TELS and assign a priority that goes to the ESD-A who assigns the work order to his employees. If a priority was set at extremely high the expectation is the work order be done within the hour and if high, by the end of the day and anything below that was entrusted to the ESD-A to determine. The administrator further stated she expected R123's work order be completed by now and stated it was an area of improvement in clarifying when the order should be completed by. A policy, Tels Work Order/Task Management Policy dated 9/1/19, indicated the facility established procedures to ensure facilities are properly maintained in a safe, healthy, and well-maintained manner. The policy lacked information regarding a timeline based on the priority for completion of work orders.	F0921		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/18/25 through 8/21/25, a standard licensing 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H54242384C (1130905), H54248667C (1130908), and H54242621C (2594335). NO licensing orders were issued. 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 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. 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.	20000		
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a complete and accurate	20550		

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20550	Continued from page 2 comprehensive nursing assessment and Minimum Data Set (MDS) oral status assessment was performed for 1 of 1 resident (R69) reviewed for dental status. R69's annual Minimum Data Set (MDS) dated 1/2/25, indicated R69 had severe cognitive impairment, substantial/maximal assistance for personal hygiene (excluding oral hygiene) and supervision or touching assistance for oral hygiene. The MDS further indicated rejection of care behavior not exhibited. R69's MDS indicated no "Obvious or likely cavity or broken natural teeth" and no "Inflamed or bleeding gums or loose natural teeth." R69's MDS section V indicated care area assessment (CAA) for dental care was not triggered. R69's diagnoses included dementia, anxiety, mood disorder, and generalized weakness. R69's quarterly MDS dated 4/1/25 indicated no "mouth or facial pain, discomfort or difficulty with chewing." R69's quarterly MDS dated 6/30/25, indicated no "mouth or facial pain, discomfort or difficulty with chewing." R69's care plan revised 1/25/24, indicated R69 had an ADL (activities of daily living) self -care deficit with intervention of "ORAL CARE: I have my own teeth: I require set up supervision BID [twice a day] and assist to finish as needed. Fluoride rinse." R69's care plan further indicated R69 had a potential oral/dental health problem and instructed staff to "Complete an oral assessment/observation on [R69] per policy…Provide mouth care as per ADL personal hygiene." R69's oral care task sheet last revised on 2/2/24, indicated, "Supervise resident with oral hygiene. Instruct fluoride rinse for 1 minute then expectorate." The task sheet indicated completion of this task twice a day in the 30 day lookback period. R69's dental consult assessment form dated 12/9/24, indicated, "Obvious or likely cavity or broken natural teeth" and "Inflamed or bleeding gums or loose natural teeth." The assessment further indicated, "Resident Needs Direct Staff Assistance" for daily oral care and recommended, "Toothbrushing each morning and evening, brush teeth and gums for approximately 2 minutes, as tolerated, using a soft toothbrush and fluoride toothpaste." R69's progress note dated 1/2/25 at 9:29 a.m., indicated, "…Oral/dental findings not within normal limits, any interventions and notifications [if applicable]…" with no new interventions identified.	20550		

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20550	Continued from page 3 R69's dental consult note dated 1/15/24, indicated, "Obvious or likely cavity, inflamed natural teeth, maintains oral care independently and needs direct staff assistance. Toothbrushing BID." R69's comprehensive nursing data collection dated 12/31/24, indicated, "Oral examination results-check all that apply…a. Broken or loosely fitting full or partial denture [chipped, cracked, uncleanable, or loose] b. No natural teeth or tooth fragment[s] [edentulous] c. Abnormal mouth tissue… d. Obvious or likely cavity or broken natural teeth e. Inflamed or bleeding gums or loose natural teeth…f. Mouth or facial pain, discomfort or difficulty with chewing." All of the boxes were unchecked (no issues identified). R69's provider order dated 6/16/25, indicated referral for oral surgery for a tooth extraction. During observation and interview on 8/18/25 at 7:02 p.m., R69 had some missing and some discolored and decaying teeth. R69 stated sometimes her mouth hurt and could not remember if she had had any dental work done recently. During observation and interview on 8/19/25 at 1:27 p.m., R69 stated no one helped when she brushed her teeth, and she can do it on her own. R69 could not tell me if she brushed her teeth this morning. Her toothbrush appeared to be in the same position as it was the previous evening. During observation and interview on 8/20/25 at 10:07 a.m., R69 in her wheelchair in the common area. R69 stated she did not brush her teeth this morning and no one offered to assist. R69 stated on occasion someone will help or offer to help, but could not articulate how often. R69 stated she would not refuse assistance with oral care. During interview on 8/20/25 at 12:13 p.m., family member (FM)-B stated she did not think R69 experienced a lot of tooth or mouth pain currently, therefore, they had chosen to delay a recommended tooth extraction for now. FM-B stated the family did not want to put R69 through oral surgery and sedation unnecessarily. FM-B further stated she did not think R69 was capable of independent oral care, and she did not believe staff brushed R69's teeth twice a day but could not say for sure. During interview on 8/20/25 at 1:45 p.m., nursing assistant (NA)-A stated R69 needed help with showers weekly and chin hairs were removed on bath day. NA-A	20550		

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20550	Continued from page 4 stated R69 required set up for brushing teeth and should be done every day and should encourage R69 to complete oral care. NA-A stated R69's oral care task was basically signing off that she was set up and encouraged to complete oral care. NA-A stated she would assist as needed. During interview on 8/20/25 at 1:58 p.m., registered nurse (RN)-B stated would expect staff to sign off tasks only if completed and to document any refusals appropriately. During follow up interview on 8/20/25 at 2:29 p.m., RN-B stated the floor nurse was responsible to complete the annual nursing comprehensive assessment. RN-B stated the assessment should accurately reflect the resident's status since the bedside assessments drive the MDS assessments. RN-B further stated R69's comprehensive assessment was not completed appropriately which would affect the accuracy of the MDS, care plan and potentially the care she received. During interview on 8/20/25 at 2:34 p.m., director of nursing (DON) stated expectation for nurses to accurately assess residents and complete the bedside assessments timely and completely. DON further stated the bedside assessments drive MDS coding which drive care plan revisions and could affect the care a resident received. Facility policy Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission dated March 2025, indicated the facility interdisciplinary team would work together by completing assigned assessments. Accurate assessments require collecting data via multiple sources including evaluation of the resident, along with input from the resident, the resident's physician, family and direct care staff on all shifts. Further, the assessment should include date from the resident's medical record. The facility policy further indicated the Care Area Assessment [CAA] process is "designed to assist the assessor to systematically interpret the information recorded on the MDS. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the team and resident." The policy continues, the "care plan is an interdisciplinary communication tool. It describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. SUGGESTED METHOD OF CORRECTION: The director of nursing	20550		

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20550	Continued from page 5 (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20550		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure interventions were implemented for 1 of 2 residents (R44) reviewed for pressure ulcers. Findings include: R44's quarterly Minimum Data Set (MDS) dated 6/24/25, indicated R44 was cognitively impaired and had diagnoses of chronic respiratory failure and heart failure. R44 was dependent on staff for dressing and bed mobility. Furthermore, R44 had a stage 2 pressure ulcer. R44's pressure injury care area assessment dated 9/26/24, indicated R44 was at risk for pressure injury related to incontinence and decreased mobility.	20900		

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20900	Continued from page 6 R44's bowel, bladder and skin risk assessment dated 6/24/25, indicated R44 was at mild risk for skin breakdown related to pressure and incontinence. Interventions included heel suspension/protective devices. R44's skin and wound evaluation dated 8/13/25, indicated R44 had a stage 2 right heel pressure injury that was identified on 6/25/25. R44 R44's provider and nursing orders indicated: -on 12/20/24, R44 required blue boots to booth heels (heel protectors) when up in wheelchair every day and evening shift. -on 3/19/25, R44 required right calf elevation to float right heel with a pillow. -on 4/8/25, R44 required assistance with placing pillows to offload feet from pressing the bottom of the padded foot box on the wheelchair and to offload heels and keep feet separated. R44's nursing assistant care sheet for the time of survey was requested however was not provided. R44's care plan revised 10/10/24, indicated R44 was at risk for impaired skin integrity related to incontinence, edema, and decreased mobility. R44 had a history of open area on right heel and was prone to bruising. Interventions included a pressure reducing bed and wheelchair cushion and staff repositioning upon waking, after breakfast and lunch, before supper, at bedtime and as needed. R44's care plan lacked indication R44 required heel elevation as indicated in the orders. An observation on 8/18/25 at 12:21 p.m., R44 was being wheeled out of their room to lunch. R44's wheelchair had a padded support on the legs of the wheelchair. R44's right leg was internally twisted and was rubbing against the other foot and R44's heels were resting on the supportive legs. R44 had no pillows or devices to elevate her heels. An observation on 8/19/25 at 8:49 a.m., R44 was in her room sitting up in their wheelchair. R44's heels were resting on the wheelchair support box and were not elevated with pillows or other devices. An observation on 8/20/25 at 6:44 a.m., trained medication assistant (TMA)-A entered R44's room to administer medication. R44 was laying on her back in	20900		

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20900	Continued from page 7 bed. R44's legs were covered, and had pillows placed under their knees, pushing the knees up in the air. TMA-A raised the head of bed and administered R44'smedications. TMA left without ensuring R44's heels were not resting on the mattress. An observation on 8/20/25 at 7:58 a.m., nursing assistant (NA)-B entered R44's room and offer to get up for the day. R44 stated she was tired and wanted to sleep. NA-B stated they would return on a while and left without ensuring R44's heels were elevated off the bed. An observation on 8/20/25 at 9:53 a.m., R44's call light was answered by NA-C. R44 stated they were ready to get up for the day. NA-C pulled back the blankets and R44 had no blue boots in place and had pillows tucked underneath both knees. R44's heels were sitting on the bed. R44 complained of pain in the right middle part of the foot. R44's heel has no dressings in place and no open wound was seen. NA-C requested licensed practical nurse (LPN)- A to assess the foot. R44 requested pain medications and LPN-A left to obtain them. NA-B then entered to assist NA-C to transfer R44 via full lift. R44 was lifted in their wheelchair. R44 was not offered blue boots or heel elevation with pillows before brought out to breakfast. When interviewed on 8/20/25 at 10:33 a.m., NA-C stated R44 required assistance with dressing, transferring and repositioning but was independent with eating. NA-C stated sometimes R44 did not want to get up until later in the day and it could be different each day. NA-B verified R44's heels were resting on the bed at the start of cares and did not have heels elevated or blue boots in place. NA-B further acknowledged R44 did not have heels off loaded when up in the wheelchair. Hospice had gotten the foot box for R44 but was not aware of needing to elevate R44's heels. NA-C stated it had been a while since the resident had worn blue heel boots and that was taken off the care sheet a long time ago. NA-C pulled out the care sheet and verified there was no mention of blue boots when and how to keep them on or the need to elevate heels when in bed or in the chair. When interviewed on 8/20/25 at 10:40 a.m., licensed practical nurse (LPN)-A stated R44 had a heel pressure wound that had just resolved and was at risk of further pressure injuries. R44 had recently received the foot box and that was better for their feet than the pedals. LPN-A verified R44 still used the blue boots and the aides should be putting them on. Furthermore, LPN-A stated R44's heels should be elevated in bed and when	20900		

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20900	Continued from page 8 in the chair. When interviewed on 8/21/25 at 9:56 a.m., registered nurse (RN)-A stated R44's heel wound had just resolved. Staff were expected to follow orders and interventions to help prevent any further pressure wounds from developing. When interviewed on 8/21/25 at 12:01 p.m., the Director of Nursing (DON) expected staff to follow orders and any determined interventions for the resident. If a resident was refusing the interventions, that would be documented. This was important to prevent any further wounds. A facility policy titled Skin Integrity Management Policy revised 10/2022, directed staff to implement preventative measures and provide appropriate treatment according to standards of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		
20910	Rehab - Incontinence CFR(s): MN Rule 4658.0525 Subp. 5 A.B Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and	20910		

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20910	Continued from page 9 B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure a comprehensive bladder assessment was completed and toileting program established for one of one residents (R7) reviewed for bladder continence. Findings include: R7's admission MDS dated 7/13/25, indicated R7 had cognitive impairment and diagnoses of hemiplegia (weakness on one side of the body) from a cerebral hemorrhage (brain bleed). R7's Bowel, Bladder and Skin Risk assessment dated 7/11/25, indicated R7 had a foley catheter and was continent of bowel and bladder prior to their cerebral hemorrhage. R7's Bowel, Bladder and Skin Risk assessment dated 7/30/25, indicated R7's foley had been removed and R7 had functional incontinence (incontinence due to a decrease in mental or physical abilities) with no voiding patterns. R7's quarterly Bowel, Bladder and Skin Risk assessment dated 8/4/25, indicated R7 had no bladder elimination patterns and had functional incontinence. R7 can identify the urge to void and was able to use the call light for assistance. R7's Bowel, Bladder and Skin Risk assessment dated 8/11/25, indicated R7's skin assessment however, lacked any bowel or bladder assessment. R7's IDT communication dated 8/13/25, indicated R7 was ablet to be transferred with a stand lift and 2 nursing staff members. R7's medical record lacked indication R7 had been assessed for bladder continence after being able to transfer with nursing staff. R7's care plan dated 7/13/25, indicated R7 required toileting every 2 hours and as needed. When interviewed on 8/18/25 at 1:47 a.m., R7 stated she was frustrated with not being able to use the toilet.	20910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/21/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20910	Continued from page 10 R7 stated she was aware of when needing to void, but there was often delays with staff needing a second person and often was not able to wait any longer and would void in their brief. Furthermore, R7 stated staff informed her it was policy for residents to void in the brief and then get cleaned up. If R7 needed to have a bowel movement, then staff would help them into the bathroom. R7 stated they “just don’t want to do that…voiding in my pants doesn’t make me feel very good”. When interviewed on 8/21/25 at 9:27 a.m., nursing assistant (NA)-D stated R7 was moving much better than when they were initially admitted and was able to use the call light and make their needs known. NA-D further stated R7 would call when needing the bathroom but was usually incontinent. R7 required a stand lift to assist in transferring to the wheelchair or the bathroom. When interviewed on 8/21/25 at 9:37 a.m., registered nurse (RN)-C stated when a resident was admitted, their bladder function was assessed. A bladder re-assessment was then completed if there were any changes. When residents were alert and able to ask to use the bathroom, we would offer a brief if they were ok with it just in case. This was especially for those with mobility issues, and it may take longer to get them up. RN-C stated if a resident was able to use the toilet, staff should be getting them up. If a resident was on a toileting program, it would be included on the care plan. RN-C stated R7 would use the call light when needing to use the bathroom, however, was not on a toileting program yet as mobility was just starting to improve. RN-C acknowledged an assessment should have been completed with her improvement in mobility, but did not see one completed. When interviewed on 8/21/25 at 9:48 a.m., occupational therapist (OT)-A stated therapy recommends how residents would transfer and stated R7’s transfer status had been updated a week or two ago. R7 was able to use the stand lift with an assist of one nursing staff member and should be able to use the toilet if wanted to. When interviewed on 8/21/25 at 9:56 a.m., RN-A stated a bladder assessment was completed upon admission and then with any changes like a foley being removed, or mobility changes. RN-A acknowledged R7 did not have an updated assessment completed after their mobility was upgraded from therapy. When interviewed on 8/21/25 at 12:03 p.m., the Director of Nursing (DON) expected staff to complete a bladder	20910		

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20910	Continued from page 11 assessment to be done when a catheter was removed and when transfer assessments were upgraded from therapy. The DON further stated this was important to ensure the care plan was individualized to the resident and work to have them function normally if they were able to. A facility policy titled Bowel and Bladder Assessment Policy revised 9/2018, directed staff to screen residents upon admission and with change in condition- an individualized toileting care plan will then be implemented. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20910		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure hand hygiene was completed for 2 of 3 residents (R7, R44) observed for personal cares. Furthermore, the facility failed to ensure shared mobility equipment was cleaned in between resident use. Findings include: R44's quarterly Minimum Data Set (MDS) dated 6/24/25, indicated R44 was cognitively impaired and had diagnoses of chronic respiratory failure and heart failure. R44 was dependent on staff for dressing and bed mobility. Furthermore, R44 had a stage 2 pressure ulcer. An observation on 8/20/25 at 9:53 a.m., R44's call	21375		

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21375	Continued from page 12 light was answered by nursing assistant (NA)-C. R44's door had a sign that read enhanced barrier precautions (EBP)and instructed staff to gown and glove when providing close contact cares. R44 stated they were ready to get up for the day. After gathering supplies, NA-C performed hand hygiene and donned a gown and gloves. NA-C assisted R44 with upper body dressing and placed tubi-grips on feet. NA-B entered R44's room in a gown and gloves to assist with R44's brief change. NA-C removed the front of the brief and tucked down. R44's front side was cleaned by NA-C before NA-B assisted R44 to turn. NA-C then finished cleaning R44 from the back, tucked and removed the urine soaked brief and placed in the garbage. NA-C then opened a clean brief and set on the bed. NA-C removed gloves and without hand hygiene placed new gloves and placed the clean brief under R44. NA-B and NA-C continued to get R44 dressed and transferred to the wheelchair for breakfast. When interviewed on 8/20/25 at 10:33 a.m., NA-C verified hand hygiene was not completed after removing soiled gloves and before placing new ones. NA-C stated it was hard in the moment to do that when in the middle of the work and trying to get the resident finished and transferred. R7's admission MDS dated 7/13/25, indicated R7 had cognitive impairment and diagnoses of hemiplegia (weakness on one side of the body) from a cerebral hemorrhage (brain bleed). R7 required tube feeding for nutritional needs. R76's quarterly MDS dated 5/13/25, indicated R76 had cognitive impairment and diagnoses of heart failure. R76 required substantial assistance for transfers and toileting. An observation on 8/21/25 at 8:46 p.m., Occupational therapist (OT)-A entered R7's room for treatment. R7's door had a sign that indicated R7 required EBP and instructed staff to use a gown and gloves with close contact cares. OT-A was going to assist R7 with a morning bathroom routine. After bringing in a stand lift, OT-A performed hand hygiene and donned gown and gloves. OT-A then assisted R7 to the toilet with the stand lift. R7 used their hands to grab the bars of the stand lift during transfer. Once over the toilet, OT-A removed R7's soiled brief and lowered R7 to the toilet. OT-A then removed gloves and without hand hygiene, donned clean gloves. R7 was finished and then physical therapist (PT)-A entered the room to co-treat. R7 was then lifted back into the standing position an OT-A cleaned R7, changed gloves and without hand hygiene, placed new ones before placing a new brief on R7. PT-A	21375		

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21375	Continued from page 13 and OT-A assisted R7 using the stand lift into the wheelchair, R7 had grabbed the stand lift to hold on during transport. Without cleaning the stand lift, OT-A pushed it out into the hall. OT-A then removed gown and gloves, performed hand hygiene and escorted R7 down to therapy without cleaning the stand lift used to assist R7. At 9:13 a.m., trained medication assistant (TMA)-A and NA-C wheeled the stand lift just used for R7 into R349's room. At 9:19 a.m., walked out of the room without the lift. AT 9:25 a.m., NA-C exited R76's room with the lift and cleaned it before leaving it in the hallway. When interviewed on 8/21/25 at 9:27 a.m., NA-C verified the lift taken into R76's room was not cleaned before use. Furthermore, NA-C stated lifts were cleaned after each resident use when placed in the hallway. When interviewed on 8/21/25 at 9:48 a.m., OT-A verified they had not performed hand hygiene with glove exchanges and had not cleaned the stand lift after R7's use. OT-A stated there was no hand sanitizer in the bathroom and she didn't want R7 to be in the stand lift too long but should have washed after glove removal. OT-A wasn't sure of the process of cleaning the lifts and believed once in the hallways, nursing staff wiped them down. When interviewed on 8/21/25 at 9:56 a.m., registered nurse (RN)-A stated lift equipment should be wiped down after each resident use. Whenever removing gloves, staff should be washing their hands or using hand sanitizer. When interviewed on 8/21/25 at 12:01 p.m., the Director of Nursing (DON) expected hand hygiene to be completed with each glove exchange and lift equipment to be sanitized after each resident use. A hospital policy titled Infection Control, Hand Hygiene revised 2020, directed staff to perform hand hygiene after removing personal protective equipment (PPE, gowns, gloves, etc) and before donning PPE. A facility policy titled Mechanical Lift Cleaning Policy dated 7/2018, directed staff to clean the lifts between residents when the resident has an infectious disease, or the resident touched the lift. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should re-educate nursing staff to appropriately implement correct hand hygiene when lift equipment required cleaning after resident use. The DON	21375		

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21375	Continued from page 14 or designee could review and revise policies to ensure appropriateness. The DON or designee should perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21685	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 2 Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure a maintenance work order was followed up on timely for a resident who required padding at the dining table (R123). Findings include: R123's Medical Diagnosis form indicated the following diagnoses: Parkinson's disease with dyskinesia (involuntary movements), muscle weakness, and pain in left shoulder. R123's Optional State Assessment (OSA) dated 7/17/25, indicated intact cognition, required extensive assistance with bed mobility, transfers, eating, and toilet use. R123's quarterly Minimum Data Set (MDS) dated 7/17/25, indicated R123 had impairment on one side of his upper body extremities, and used a wheelchair. R123's care plan dated 7/29/25, indicated R123 had a self-care deficit and required assistance to and from meals. R123's care plan dated 7/29/25, indicated R123 had limited physical mobility due to Parkinson's disease, left should and left knee pain, and used a wheelchair with assist of one to propel to all destinations.	21685		

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21685	Continued from page 15 R123's progress notes dated 8/12/25 at 9:26 p.m., indicated R123 had a bruise and skin tear to his right forearm and R123 stated his arm was caught in between the dining room table and his wheelchair. R123's progress note dated 8/19/25 at 9:39 a.m., indicated R123 sustained a skin tear to the top of his left hand and bumped his hand on the dining table and a TELS order was placed for padding to his spot at the dining table. R123's progress note dated 8/19/25 at 10:04 a.m., indicated R123 had a skin tear to the right arm and bruises to the left arm and interventions based on the root cause analysis indicated to use caution when wheeling resident up to the dining table. R123's progress note dated 8/19/25 at 10:17 a.m., indicated R123 got his right arm caught between the wheelchair and the dining room table and a TELS was placed for padding at the table. The facility open TELS report dated 8/13/25 at 2:59 p.m., indicated a work order was placed requesting padding on table number 9 on the third-floor dining room. During interview and observation on 8/18/25 at 3:59 p.m., R123 was sitting in his recliner and family member (FM)-A stated R123 could not respond quickly when getting pushed up to the dining room table and bumped into the table. During observation on 8/20/25 between 12:11 p.m., and 12:27 p.m., staff knocked on R123's door and entered his room. At 12:26 p.m., an unidentified staff person pushed R123 out to the dining room in his wheelchair. R123 was brought to the dining room table, table number 9, and his hands were resting on his knees. The staff person moved the chair out and brought R123 to the table and R123 placed his hands on the table and the staff person moved R123 closer to the table without striking R123's hands. During observation on 8/20/25 at 2:11 p.m., R123's table did not have any padding. During interview on 8/20/25 at 2:13 p.m., licensed practical nurse (LPN)-A stated R123 sat at table number 9. LPN-A stated when a TELS work order was placed, they received a response immediately or the same day. During interview on 8/21/25 at 9:29 a.m., environmental	21685		

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21685	Continued from page 16 services director (ESD)-A stated when a work order was submitted, it had a priority of low, medium, or high and critical. ESD-A stated most work orders were a medium priority and further stated there was not a specific time requirement for completing work orders and was based on judgment. ESD-A further stated there were a lot of medium priority work orders and a lot of them were done the same day and some are not completed that day or even that same week. ESD-A stated their lead engineer recently retired. ESD-A stated the padding for the tables was for residents who bumped their hands and therapy came up with the idea to apply padding. ESD-A stated the work order was placed by registered nurse (RN)-A and further stated they were out of the padding and asked engineer technician (ET)-B if the padding was ordered and ET-B stated he forgot to order the padding 8/20/25, and would do it today. During interview on 8/21/25 at 9:48 a.m., registered nurse (RN)-A stated she followed up on falls and skin issues and stated R123 required the table padding because his hands get caught on the edge of the table when going out to eat and obtained skin tears and bruises. RN-A stated she spoke with environmental services, and they had to order the padding and was not sure how long work orders took to be completed but stated they could prioritize whether the request was low, medium, or high. RN-A stated priority was usually sent as a medium and added it was urgent to have the padding on the table to prevent any bruises or skin tears and would have expected the work order to have been completed by now. Household coordinator verified R123 sat at the first table on the left when entering the dining room from their office which was also table number 9. During interview on 8/21/25 at 10:23 a.m., the administrator stated staff can submit a TELS and assign a priority that goes to the ESD-A who assigns the work order to his employees. If a priority was set at extremely high the expectation is the work order be done within the hour and if high, by the end of the day and anything below that was entrusted to the ESD-A to determine. The administrator further stated she expected R123's work order be completed by now and stated it was an area of improvement in clarifying when the order should be completed by. A policy, Tels Work Order/Task Management Policy dated 9/1/19, indicated the facility established procedures to ensure facilities are properly maintained in a safe, healthy, and well-maintained manner. The policy lacked information regarding a timeline based on the priority for completion of work orders.	21685		

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21685	Continued from page 17 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the expected timeframe of work order completion. The DON or designee, could coordinate with maintenance to a safe, clean, functional and homelike environment. The DON or designee, could review policies and complete periodic audits of the work orders to ensure timely completion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/19/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Presbyterian Homes of Arden Hills was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		09/18/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

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

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K0000	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: PRESBYTERIAN HOMES OF ARDEN HILLS is a 4-story building with full basement. The building was constructed at two different times. The original building was constructed in 1978 and was determined to be of Type II (222) construction. In 2006, an addition was constructed to the West side of the building that was determined to be of Type II (222) construction. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 128 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		

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K0000 K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect the Emergency lighting of at least 30 seconds monthly and 90 minute annually in accordance with NFPA 101, 7.9. 20.2.9.1, 21.2.9.1, 7.9. This deficient finding could have a widespread impact on the residents within the facility. On 08/19/2025 between 10:02 AM, it was revealed by a review of available documentation that the emergency lighting documentation that was presented at the time of the survey that the 30-second monthly testing was not completed in February and July 2025.	K0000 K0291	The 30-second testing of all exit lighting was completed on 8/31/2025 and is now up to date. The Electronic work order system Tel's has been changed to show that this task should be completed every month. The ESD will review each month to confirm completion of the task and that proper documentation is recorded. The REM will review the documentation records annually at the time of the Annual Facilities Review.	09/18/2025
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K0353	The quarterly inspection of the sprinkler system was completed by Viking Sprinkler on 8/28/2025. The contract for sprinkler testing with Viking sprinkler has been adjusted to include the quarterly inspection of the sprinkler system. ESD will confirm documentation that quarterly Testing is recorded in the life safety manual. The REM will review these documents during the Annual Facility Review process.	09/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0353 SS = F	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a widespread impact on the residents within the facility. On 08/19/2025, at 9:35 AM, it was revealed by a review of available documentation the facility was unable to locate the necessary documentation to show that the sprinkler systems quarterly inspections had been completed. 2. On 08/19/2025 at 10:28 AM , it as revealed by observation that there were wires and conduit resting on the sprinkler pipe above the ceiling near resident room 418.	K0353		
K0711 SS = F Bldg. 01	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is NOT MET as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to provide a complete fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, sections 33.7.1.1 and 33.7.1.2. This deficient finding could have a widespread impact on the residents within the facility. On 08/19/25, between 8:30 AM and 9:30 AM, it was revealed by a review of available fire and emergency	K0711	All staff in the care center have been given training on the location of the evacuation Plan. This was done by including the training at the stand-up. On 8/31/2025. The Monthly staff evacuation training documentation has been adapted to include a question and bullet point to include the locations of the plan documents. In addition, the locations of this plan will be included in the annual staff meeting at Johanna Shores. ESD will confirm that the monthly drill and training cover the location of the plan documents.	09/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

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K0711 SS = F Bldg. 01	Continued from page 4 evacuation policy documentation and an interview with staff that the Fire Emergency and Evacuation Plan was unable to be located.	K0711		