DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 26, 2024

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: CCN: 245613
Cycle Start Date: September 26, 2024

Dear Administrator:

On November 15, 2024, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 7, 2024

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: CCN: 245613
Cycle Start Date: September 26, 2024

Dear Administrator:

On September 26, 2024, 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:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 December 26, 2024 (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 March 26, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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
E 000	Initial Comments On 9/23/24 to 9/26/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the	E 018		11/13/24

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

Electronically Signed | 10/15/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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
E 018	Continued From page 1 following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.	E 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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
E 018	Continued From page 2 *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement emergency preparedness policies and procedures that included a system to track on-duty staff during evacuation in the case of an emergency, Findings include: The facility Emergency Operations Preparedness Plan Prevention, Preparedness, Response & Recovery updated July 2024, did not include a system to track the location of on-duty staff in the event of an evacuation during an emergency. The Plan had a checklist in the Long Term Care Evacuation Go-Box policy, updated August 5, 2021 with a column that had a heading of	E 018	The facility has completed a review of the emergency preparedness policies and procedures. The facility has created a new policy called Long Term Care Staff Tracking to address how to track staff in an emergency. The policy has been placed in the Emergency Preparedness Binder and will be reviewed annually with the Emergency Preparedness team. This will be added in our next QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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
E 018	Continued From page 3 "Established procedures to account for all residents and staff (no one left behind)", however, the plan failed to address what the procedure(s) were and how to implement it. During interview with administrator on 9/25/24 at 12:45 p.m., administrator confirmed the emergency preparedness policy and procedures did not include a system to track on-duty staff during an evacuation.	E 018		
F 000	INITIAL COMMENTS On 9/23/24 to 9/26/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H56138380C (MN103456) 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.	F 000		
F 575	Required Postings	F 575		11/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 575 SS=C	Continued From page 4 CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post accessible contact information of all pertinent State agencies or Ombudsman information for 4 or 4 residents (R12, R20, R46, and R47), who routinely attend resident council. This had the potential to affect all 52 residents who resided in the facility. Findings include: During the resident council meeting held on 9/25/24 at 10:01 a.m., with a state surveyor, R12,	F 575	The facility has posted the Ombudsman□s contact information including the mailing address, telephone number, fax number and email address in a location accessible to all residents and their representatives. All new residents are already being provided with the Ombudsman□s contact information upon their admission to the facility. An audit of all regulatory required postings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 575	Continued From page 5 R20, R46, and R47 participated and indicated they were regular attendees of the Resident Council meetings in the facility. Upon asking, R12, R20, R46, R47 stated they were unaware of who the ombudsman was and did not know where the ombudsman information was located or posted in the building. While on survey in the facility from 9/23/24 through 9/26/24, no posting or contact information for the Ombudsman was observed or noted within the facility or on the additional units of the nursing home and were not accessible to the residents to view or read. On 9/25/24 at 2:40 p.m., the director of Nursing (DON) and the administrator confirmed the Ombudsman contact information was not posted. Both the DON and the administrator stated they believed social services had the information; however, it was not posted or visibly readable or accessible by the residents or visitors unless they were to ask for it. On 9/25/24 at 2:58 p.m., during an additional interview, the administrator provided the contact business card/handout for the ombudsman and confirmed again the information was not posted in the facility. On 9/26/24 at 8:34 a.m., the DON confirmed the ombudsman contact information was not posted and was important to post and provide contact information as the Ombudsman was an advocated for the resident and should be available to them as a support system. A policy regarding the Ombudsman information was requested and none was provided.	F 575	has been conducted. No other irregularities were identified. The Care Center Administrator will conduct quarterly audits of all required postings and update them as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to hold, at a minimum, quarterly care conference meetings with the resident and their representative to allow the resident and/or representative the opportunity to review and participate in the revision of the care plan for 1 of 2 residents (R13) reviewed for care conferences.	F 657	Resident #13 care conference was held on 9/27/2024 and the plan of care was reviewed with the resident. Household Coordinators completed an audit on all residents to ensure care conferences were conducted in the last 90 days.	11/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7 Findings include: R13's quarterly Minimum Data Set (MDS), dated 8/28/24, indicated R13 was admitted to the care facility on 8/28/24 and was cognitively intact. R13's electronic medical record (EMR) indicated the most current care conference was documented on 1/23/24. The care conference note, dated 1/23/24, indicated the care conference was held on 1/5/24 with R13's family, clinical staff, life enrichment, social services and R13 present. During an interview on 9/26/24 at 8:04 a.m., nurse manager and registered nurse (RN)-A confirmed R13 had not had a care conference since the documented care conference on 1/5/24. RN-A stated there had been a care conference set up but R13's representative was unavailable and it "fell through the cracks." RN-A further stated regular care conferences were important to keep families up to date on how the resident was doing. During an interview on 9/23/24 at 2:00 p.m., R13 was unable to state when he last attended a care conference and appeared to have confusion on why he was still living at the care facility, stating multiple times he unsure why he lived at the care facility. During an interview on 9/25/24 at 12:30 p.m., social worker (SW)-A stated it was her role to schedule care conferences, and it was expected to hold a care conference for each resident at admission, quarterly and if a resident had a change in condition. SW-A stated she would reach out to the resident's family (representative),	F 657	The Household Coordinators will track care conferences monthly and report to the Care Center Administrator. Monitoring of care conferences will be tracked and discussed in our IDT meetings. Reports will be generated monthly for three months. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Household Coordinators and Clinical Coordinators have been educated on this process. The Care Center Administrator will monitor and ensure continued compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8 typically via email, set a date and time for the care conference and ensure staff and family were aware. During a follow up interview on 9/25/24 at 2:30 p.m., SW-A confirmed there had not been a documented care conference for R13 since 1/5/24. SW-A stated she and the nurse manager helped arrange a video call between R13 and family on Fridays, stating the nurse manager "sat in on one" but it was not documented. A facility policy titled Care Plan Policy and Procedure, modified 11/22, indicated a resident's care plan would be reviewed at least quarterly and with any significant change and would not be complete until a care conference was held to review with the resident and/or resident representative.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		11/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 9 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to implement interventions to prevent further development of decreased range of motion for 3 of 4 residents (R2, R4, and R28) reviewed for positioning and mobility. Findings include: R2's quarterly Minimum Data Set (MDS) dated 8/8/24, indicated R2 was admitted to the facility on 6/2/2017 and had a moderate cognitive impairment and the following diagnoses: Hypertension (HTN) (high blood pressure), diabetes, hyperlipidemia (HLD) (elevated levels of fat in the blood), Parkinson's disease, epilepsy (seizure disorder), anxiety and depression. R2's Care plan dated 9/26/24, included an ambulation program to walk 400 feet with assistance twice a day. An active range of motion (ROM) program for bilateral (both sides) upper extremities five repetitions twice daily. Finally, an active ROM program to bilateral upper and lower extremities daily. The facility document R2's "Tasks" dated 9/26/24, where staff document the completion of tasks, included an ambulation program to walk 400 feet with assistance twice a day. An active ROM program for bilateral upper extremities five repetitions twice daily. Finally, a ROM program to bilateral upper and lower extremities 10 times daily. R2's Follow-up question report dated 7/26/24	F 688	A comprehensive review of the restorative care plans for residents #2, 4, and 28 has been completed. Residents # 2 was screened by a licensed occupational therapist and licensed physical therapist on 10/10/2024 with no functional changes were noted to Upper extremities ROM and daily recommended walking distance. Resident # 4 was screened by licensed occupational therapist on 10/11/2024 and licensed physical therapist on 10/9/2024. PT noted that the resident demonstrated PROM measurements equal to or better than latest measurements taken on 9/16/2022. OT assessments indicated that the resident has reduced use of LUE and increased rigidity with declining ROM. New orders for OT to evaluate and treat for LUE ROM have been obtained. Resident□s plan of care will be updated with new functional maintenance program upon completion of OT treatment. Resident # 28 was screened by a licensed occupational therapist and by a licensed physical therapist on 10/8/2024. No changes in range of motion or functional abilities were noted by either therapist discipline.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 10 through 9/24/24, included the documentation for the ROM program for bilateral upper extremities to be completed with five repetitions twice daily. For the 60 days reviewed and 120 documentation opportunities the following information was documented: Task completed: 45/120 Not applicable: 40/120 Resident Refused: 30/120 Missed/No documentation: 5/120 R2's follow up question report dated 7/26/24 through 9/24/24, included the documentation for the ambulation program to be completed twice daily. For the 60 days reviewed and 120 documentation opportunities the following information was documented: Task completed: 56/120 Not applicable: 33/120 Resident Refused: 25/120 Missed/No documentation: 6/120 R2's Follow up question report dated 8/26/24 through 9/24/26, included the documentation for the ROM program to bilateral extremities 10 repetitions daily. For the 30 days reviewed and 30 documentation opportunities the following information was documented: Task completed: 20/30 Not applicable: 7/30 Resident Refused: 2/30 Missed/No documentation: 1/30 R2's medical record lacked any documentation as to why the program was not completed or the rational for not applicable being documented.	F 688	The facility has reviewed all residents with restorative programs on their care plans and provided all staff with additional education on the importance of completing these exercises. The facility will conduct weekly random audits on 6 residents to ensure completion of nursing restorative programs x4 weeks. The Household Coordinators will review the results weekly with the IDT. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 11 R4's quarterly MDS dated 8/16/24, indicated R4 was admitted to the facility on 7/26/22 and had a severe cognitive impairment and the following diagnoses: Alzheimer's, depression, and psychotic disorder. R4's care plan dated 9/26/24, indicated a ROM program to be completed daily to bilateral lower extremities. The facility document, R4's "Tasks" dated 9/26/24, included a ROM program for 10 repetitions to bilateral upper extremities to be completed daily and a passive ROM program to lower extremity 10 repetitions daily. R4's occupational therapy (OT) discharge summary dated 7/3/24, indicated discharge recommendations to complete daily ROM to bilateral upper extremities. R4's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to bilateral upper extremities 10 repetitions daily. For the 60 days reviewed and 60 documentation opportunities the following information was documented: Task completed: 43/60 Not applicable: 12/60 Resident Refused: 4/60 Missed/No documentation: 1/60 R4's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to bilateral lower extremities 10 repetitions daily. For the 60 days reviewed and 60 documentation opportunities the following	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 12 information was documented: Task completed: 43/60 Not applicable: 14/60 Resident Refused: 2/60 Missed/No documentation: 1/60 R4's medical record lacked any documentation as to why the program was not completed or the rational for not applicable being documented. R28's quarterly MDS dated 7/11/24, indicated R28 was admitted to the facility on 2/12/21 and had a moderate cognitive impairment and the following diagnoses: cerebral vascular accident (CVA) (stroke), HTN, gastroesophageal reflux disease (GERD), HLD, thyroid disorder, hemiplegia or hemiparesis (unable to use or more one side of the body), and depression. R28's Care plan dated 9/26/24, included a passive range of motion program for the left upper extremity with 10 repetitions daily. A passive ROM program to the left lower extremity with 20 repetitions daily. The facility document R28's "Tasks" dated 9/26/24, included a ROM program for 10 repetitions to left upper extremity to be completed daily and a ROM program to lower left extremity 20 repetitions daily, and a passive ROM program to the left hand to be completed three times daily. R28's OT discharge summary dated 1/30/24, indicated discharge recommendations to complete daily gentle ROM before and after removing R28's left hand splint. R28's Follow up question report dated 7/26/24	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 13 through 9/24/26, included the documentation for the ROM to the left upper extremity 10 repetitions daily. For the 60 days reviewed and 60 documentation opportunities the following information was documented: Task completed: 25/60 Not applicable: 19/60 Resident Refused: 14/60 Missed/No documentation: 2/60 R28's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to the left lower extremity 20 repetitions daily. For the 60 days reviewed and 60 documentation opportunities the following information was documented: Task completed: 20/60 Not applicable: 24/60 Resident Refused: 14/60 Missed/No documentation: 2/60 R28's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to the left hand three times daily. For the 60 days reviewed and 180 documentation opportunities the following information was documented: Task completed: 37/180 Not applicable: 47/180 Resident Refused: 31/180 Missed/No documentation: 65/180 R28's medical record lacked any documentation as to why the program was not completed or the rational for not applicable being documented.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 14 On 9/25/24 at 1:12 p.m., the nursing assistant (NA)-A stated the NA's usually completed the ROM programs with the residents based on the directions they have on their care sheets, and would sometimes put not applicable if they did not have time to complete the ROM or if it was not completed. On 9/25/24 at 12:04 p.m., registered nurse (RN)-B stated the NA's were responsible for completing the ROM programs, and would sometimes put not applicable if the resident was not on the unit or if it was not completed. On 9/25/24 at 12:55 p.m., the RN clinical coordinator, RN-C stated the NA's were responsible for completing the ROM program and walking programs. RN-C stated their expectation was if the program was scheduled for daily, twice, or three times daily it should have been completed as often. RN-C confirmed that R2, R4, and R28's ROM programs were not being completed as ordered. RN-C stated further there was really no reason for not applicable to be documented, either there was not enough time to complete the ROM or it was not completed. On 9/26/24 at 8:34 a.m., the director of nursing (DON) confirmed that R2, R4, and R28's ROM programs were not being completed as ordered, and they expected the ROM programs for all residents to be completed every day as ordered. The DON confirmed the importance of completing the ROM programs for residents to maintain their level of functioning and to prevent contractures and maintain their ability levels. The Range of Motion policy was requested and it was not provided.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		11/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon the consultant pharmacist's recommendation for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include: R11's quarterly Minimum Data Set (MDS) dated 7/19/24, identified R11 with diagnoses of heart failure, diabetes, dementia, and anxiety and documented R11 receiving High-Risk Drug Classes of antipsychotic, antianxiety, antidepressant, opioid, antiplatelet, and hypoglycemic medications. Also, the MDS documented R11 receiving antipsychotic on a routine and as needed (PRN) basis. In addition, the MDS documented R11 on hospice. Insulin R11's physician orders (PO) dated 8/24/24 documented, "Humalog Injection Solution (fast acting insulin that lowers blood sugar in adults and children with diabetes) 100 UNIT/ML (milliliter), Inject as per sliding scale (adjusting the insulin dose based on blood glucose level) : if 200-250=2 units; 251-300=3 units; 301-350=4 units, 351-400= 5 units Call Hospice for BG>400, subcutaneously before meals for Sliding Scale to be given in addition to Scheduled 6 units SQ (subcutaneous-injection of medication between skin and muscle) TID (three times per day) before meals." R11's PO dated 9/13/24 documented, "Lorazepam Oral Tablet 0.5 mg (milligram), Give 0.5 mg by mouth three times a day for Anxiety	F 756	Resident # 11 medication regimen was reviewed by hospice nurse practitioner on 10/9/2024. The provider gave news orders for insulin and rational for continued use of lorazepam. Resident #11 did not have any negative outcome from the lorazepam and insulin dosage not being adjusted on 5/13/204 and on 6/11/2024, following pharmacy recommendations. Psychotropic and Unnecessary Medication Use policy has been reviewed. No changes were made to the policy. The facility conducted an audit of all pharmacy recommendations from the last three months to ensure that physicians have responded to each one. Pharmacy recommendations processes and expectations have been reviewed. After the pharmacy consultant provides the recommendations to the facility, the clinical coordinators will forward them to the healthcare providers for review immediately. The healthcare providers are expected to respond within 14 business days of receiving them. This process ensures that the pharmacy recommendations are reviewed in a timely manner to maintain patient care standards. A letter detailing these	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 17 AND Give 0.5mg by mouth every 2 hours as needed (PRN) for Anxiety for 30 days." Sliding Scale Insulin R11's electronic medical record (EMR) progress note (PN) titled "Pharmacy Monthly Medication Review (MMR)-Recommendation" dated 5/13/24 documented, "Medication regimen reviewed. See communication with MD and/or Nursing regarding: SSI (sliding scale insulin) ". R11's Consultant Pharmacist Communication to Physician (CPCP) form dated 5/13/24 documented: "HOSPICE resident has orders for Sliding Scale Insulin (SSI). AGS Beers criteria places SSI under the Strongly 'Avoid' category, due to the: 'Higher the risk of hypoglycemia without improvement in hyperglycemia management regardless of care setting.' CMS considers hypoglycemia an adverse event as it can contribute to falls and has been one of the top reasons for hospital readmissions. CMS guidelines suggest that "continued or long-term need for sliding scale insulin for non-emergency coverage may indicate inadequate blood sugar control' and would result in increased scrutiny. Benefits of moving away from SSI: -Reduced hypoglycemic episodes -Reduced falls -Reduced hospital re-admission -Reduced facility cost -Reduced staff time -Reduced potential F-tags during surveys -Improved patient convenience & quality of life Would you please assess if we could increase basal insulin to limit/eliminate SSI use?"	F 756	expectations will be sent to the providers. Clinical Managers have been educated on this process. Clinical Managers will conduct monthly audits of all pharmacy recommendations for 3 months and report to the Clinical Administrator. The Clinical Administrator will ensure compliance. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 18 Document marked by "Other" and handwritten "managed by Allina Endocrinology-Dr Ibid". Document signed by provider with date of 9/24/2024. Ativan R11's EMR PN titled "Pharmacy MMR-Recommendation" dated 6/11/24 documented, "Medication regimen reviewed. See communication with MD and/or Nursing regarding: Ativan". R11's CPCP form dated 5/13/24 documented: "Has orders for PRN Ativan Beers list (a medication guideline from the American Geriatrics Society to help providers safely prescribe medications for adults over age 65) states: 'Avoid benzodiazepines (any type) for treatment of insomnia, agitation, or delirium. Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents. In general, all benzodiazepines increase the risk of cognitive impairment, delirium, falls, fractures, and motor vehicle accidents in older adults. May be appropriate for seizure disorders, rapid eye movement sleep disorders, benzodiazepines withdrawal, ethanol withdrawal, severe generalized anxiety disorder, periprocedural anesthesia, and end-of-life care.' ***New CMS guidelines*** state that for non-antipsychotic psychotropic drugs (anxiolytics, hypnotics...), PRN use should be limited to 14 days UNLESS the prescriber documents the rationale for a longer duration of use in the resident's medical record, an indicated the duration for the PRN order."	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 19 The CPCP was signed by provider on 9/24/24 with clinical indication for use. During interview with director of nursing (DON) on 9/24/24 at 3:50 p.m., DON verified R11's 5/13/24 and 6/11/24 CPCP forms were scanned into the EMR but not signed by physician or provider as having been reviewed. "I don't know why there is not one [sic] I cannot find it." During interview with DON on 9/25/25 at 9:12 a.m., DON provided surveyor with 5/13/24 and 6/11/24 CPCP forms that were signed by the nurse practitioner (NP) on 9/24/24. During interview with consultant pharmacist (CP) on 9/25/24 at 10:03 a.m., CP stated he is on-site at least once a month and talks to staff about any medication concerns. CP stated his process for monthly medication reviews (MMR) is to review with staff any concerns about medication management and he then documents in the CPCP form what his recommendations are. The form will then be provided to the DON who will follow up by faxing it or providing it to the provider for a signed response. After a signed response is obtained from the provider then the order is updated in the EMR, and the signed form is downloaded into the residents EMR. CP stated, "I do not communicate with the hospice provider, and I do not communicate with Endocrinology. It is up to the facility to make sure they are doing it [forwarding the recommendations to the appropriate provider]." CP stated they were unaware the 5/13/24 and 6/11/24 MRR's were not signed by provider until 9/24/24. During interview with NP on 9/26/24 at 9:31 a.m.,	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 20 NP stated the process for her responding to the monthly pharmacist recommendations is the facility provides her a stack of CPCP forms once a month to review. NP stated the facility will receive the signed CPCP forms from her, and the facility will then update the orders in the EMR and scan the form into the EMR. If a resident is on hospice, then the hospice provider and NP work together to collaborate on a response. NP stated if the facility has difficulty getting a response from outside providers or hospice then she is asked to review the CPCP form. NP stated she was out of town in May of 2024 and the hospice provider was out of town in June of 2024 which, could explain the lack of response for the 5/13/24 and 6/11/24 MRR's. NP verified she was provided the 5/13/24 and 6/11/24 CPCP forms by the facility to review and signed them on 9/24/24. NP also stated the endocrinologist mentioned in the 6/11/24 CPCP form was no longer involved in managing R11's insulin and that the hospice provider and NP are now managing it. During interview with DON on 9/26/24 at 9:51 a.m., DON stated it was the facility's responsibility to forward the monthly CPCP forms to the appropriate provider to review and expect a response. DON stated he did not know why the 5/13/24 and 6/11/24 CPCP forms were not signed or forwarded to NP and the hospice provider to review before 9/24/24 but that it should have been. Facility policy titled Psychotropic and Unnecessary Medication Use modified July 2024 state, "All pharmacist recommendations will be reviewed with the primary physician/NP prior to implementation and with a physician's order."	F 756		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245613	A. BUILDING: _____ B. WING _____	9/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245613	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide the resident and/or the resident representative a written notice of transfer, including the reason the resident was transferred to the hospital, for 2 of 2 residents (R2 and R46) reviewed for hospitalizations.

Findings include:

R46's quarterly Minimum Data Set (MDS), dated 8/22/24, indicated R46 was admitted to the care facility on 6/6/23 and had moderate cognitive impairment.

R46's progress note, dated 3/22/24, indicated the facility transferred R46 to the hospital due to weakness and lethargy post fall.

R46's electronic medical record (EMR), including uploaded forms and progress notes, lacked documentation the facility provided R46 and/or their representative a written notice of transfer, including the reason for transfer to the hospital.

During an interview on 9/26/24 at 8:04 a.m., nurse manager and registered nurse (RN)-A stated it was expected that the nursing staff provided a copy of the written notice of transfer and send a copy with the resident to the hospital.

During an interview on 9/25/24 at 12:30 p.m., social worker (SW)-A stated they were unaware of the care facility's process for providing a resident and/or the representative a written notice of transfer.

During an interview on 9/25/24 at 2:00 p.m., the administrator confirmed a written notice of transfer and accompanying progress note was missing for R2 and R46.

During a follow up interview on 9/25/24 at 2:30 p.m., SW-A also confirmed a written notice of transfer and/or accompanying progress note was missing for R2 and R46.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245613	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 R2's quarterly Minimum Data Set (MDS) dated 8/8/24, indicated R2 was admitted to the facility on 6/2/2017 and had a moderate cognitive impairment. R2's progress notes indicated R2 was sent to the emergency department on 5/24/24 and was hospitalized from 6/30/24 through 7/2024 for increased seizure activity. R2's medical record lacked any evidence a written notice of transfer was provided by the facility to R2 or their representative. A facility policy regarding a written transfer notice with hospitalizations was requested but not received.
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the resident and/or their representative, in writing, of the care facility's bed hold policy, including any potential costs included with the bed hold, at the time of transfer to the hospital for 2 of 2 residents (R2 and R46) reviewed for hospitalizations. Findings include: R46's quarterly Minimum Data Set (MDS), dated 8/22/24, indicated R46 was admitted to the care facility on 6/6/23 and had moderate cognitive impairment.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245613	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 3

R46's progress note, dated 3/22/24, indicated the facility transferred R46 to the hospital due to weakness and lethargy post fall.

R46's electronic medical record (EMR), including uploaded forms and progress notes, lacked documentation the facility's bed hold policy was communicated to R46 and/or their representative at the time of transfer to the hospital.

During an interview on 9/26/24 at 8:04 a.m., nurse manager and registered nurse (RN)-A stated it was expected that the nursing staff ask the resident (if they were cognitively intact) at the time of transfer about a potential bed hold or call the resident representative. The nursing staff were expected to send a written copy of the bed hold policy with the resident to the hospital and keep a copy for the facility. RN-A further stated it would be expected that this communication, including what was decided, be documented in a progress note.

During an interview on 9/25/24 at 12:30 p.m., social worker (SW)-A stated if a resident was transferred to the hospital in the evening or over the weekend the nurse was expected to ask the resident and/or the resident representative if they wanted to hold the resident's bed at the time of transfer and put the communication in a progress note. A social worker or the admission coordinator would follow up with the resident's representative to ensure they wanted to hold the resident's bed and inform them of the current bed hold fees.

During an interview on 9/25/24 at 2:00 p.m., the administrator confirmed a written bed hold notice and accompanying progress note was not documented for R2 and R46.

During a follow up interview on 9/25/24 at 2:30 p.m., SW-A also confirmed a written bed hold notice and/or accompanying progress note was not documented for R2 and R46.

R2's quarterly Minimum Data Set (MDS) dated 8/8/24, indicated R2 was admitted to the facility on 6/2/2017 and had a moderate cognitive impairment.

R2's progress notes indicated R2 was sent to the emergency department on 5/24/24 and was hospitalized from 6/30/24 through 7/2/2024 for increased seizure activity.

R2's medical record lacked any evidence the facility's bed hold policy was communicated to R2 or their representative at the time of the transfers.

A facility policy titled Minnesota Bed Hold Policy, modified 11/22, indicated when the facility transfers a

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245613	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 4 resident to the hospital, written information of the bed hold policy would be given to the resident and/or the resident representative. The policy further indicated before a resident left for hospitalization, the facility would attempt to give the resident a copy of the bed hold policy, the resident services staff would contact the resident and/or their representative to inquire about the bed hold and the discussion would be documented in a progress note.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on October 3,2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Presbyterian Homes of North Oaks, 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	K 000		

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

Electronically Signed | 10/15/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 000	Continued From page 1 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 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. Presbyterian Homes of North Oaks is on the 1st floor (ground level) of a 3-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 2005 and was determined to be of Type II(111) construction. In 2008 a 3 story addition was constructed to the East and was determined to be of Type II(111) construction. The nursing	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 000	Continued From page 2 home uses only the 1st floor and is fire separated from the other floors. The facility has a capacity of 60 beds and had a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 200 SS=F	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview the facility was not following the applicable NFPA 101 and NFPA 80, 5.2.3.5.2, for testing and inspecting of the facility fire doors. This deficient finding could have a widespread impact on the residents. Findings include: On 10/03/2024, between 8:30 AM and 11:00 AM, document review and and staff interview revealed that the facility had not fully identified all of the	K 200	To meet the requirements of NFPA 101 18.2/19.2 NFPA 80 5.2.3.5.2 for testing and inspecting of facility fire doors, The facility Environmental Services Director (ESD) and the Regional Engineering Manager (REM) will fully identify all the rated fire doors that are required to be annually inspected. Doors that were not inspected previously will be inspected by the ESD by 10/31/2024 A task will be created and entered into the Electronic Work Order System (ELWOS) Task	10/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 200	Continued From page 3 rated fire doors and was not inspecting them annually. An interview with the Environmental Services Director verified this deficient finding.	K 200	schedule to annually inspect and log the inspection of all required fire doors. The ESD will be responsible for ensuring this door inspection task takes place annually as required. The REM will be responsible for reviewing the door inspection logs during the document review portion of the Annual Facility Review. This task will be entered into the ELWOS by the REM on or before 10/31/2024	
K 291 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/03/2024, between 8:30 AM and 11:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have been testing the emergency lighting in the facility for 90 minutes annually. An interview with the Environmental Services	K 291	To meet the requirements of NFPA 101 (12) Life Safety Code sections 19.2.9.1 and 7.9.3.1.1 testing and maintaining emergency lighting, an annual task will be entered into the Electronic Work Order System that requires conducting and logging the annual 90 minute test. A 90 minute test will be conducted by the ESD or his proxy by 10/31/2024. The ESD will be responsible for ensuring this annual test is completed and logged as required. The REM will review the 90 minute annual battery powered emergency lighting logs during the AFR document review. The task will be entered into the EWOS on or before 10/31/2024	10/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 291	Continued From page 4 Director verified this deficient finding at the time of discovery.	K 291		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10.1.5.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 10/03/2024, between 8:30 AM and 11:00 AM, it was revealed by observation that there were six doors located on North and South Gable Units that had signs indicating emergency exit, without appropriate exit signs to identify them and additional signage that listed them as "Not an Exit". The facility needs to determine the need of these doors and properly identify them to eliminate any confusion. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 293	To meet the signage requirements for egress doors of NFPA 101 (12) section 7.10.1.5.1 the doors identified as not having appropriate signage to indicate these doors were not to be used as emergency exits will be made to comply with the signage requirements by having appropriate signage affixed to the door as required. The doors will first be evaluated to determine the need and usage of the doors before identifying them as Not an Exit The ESD and REM will be responsible for evaluating these doors by 10/31/2024. The ESD will be responsible for procuring code compliant signage and affixing them to the doors on or before 10/31/2024. The REM will review door signage during the AFR.	10/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to conduct visual inspection of manual fire alarm boxes (pull-stations) per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.14.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/03/2024, between 8:30 AM and 11:00 AM, it was revealed by observation that that in the nurses station on the North Gable, the fire alarm pull station was being obstructed by a chair. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 345	To meet the requirements of NFPA 101 (12) Life Safety Code section 19.3.4.1.9.6.1.3, and NFPA 72 (10)section 17.14.5 a monthly task to inspect fire alarm pull stations to ensure they are available for use will be entered into the ELWOS. The REM will be responsible for entering this task on or before 10/31/2024. The ESD will be responsible for ensuring this monthly task is completed on a timely basis. The REM will review this task log during the AFR documentation review.	10/31/24
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351		10/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 351	Continued From page 6 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, section 8.5.5.3.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 10/03/2024, between 8:30 AM and 11:00 AM, it was revealed by observation that the fire department connection's were not being inspected quarterly. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 351	To meet the requirements of NFPA 101 (12) Life Safety Code sections 19.3.5.1, and 9.7.1.1, and NFPA 13 (10) section 8.5.5.3.1, a quarterly task will be entered into the ELWOS to inspect the external fire department connections to ensure they are clear of any obstructions, and are readily available for the fire department to use. The task will be entered into the ELWOS by the REM on or before 10/31/2024. The FDC□s will be inspected by 10/31/2024 The ESD will be responsible for ensuring this task is completed in a timely manner. The REM will review this inspection log during the AFR document review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/03/2024 between 8:30 and 11:00 AM, it was revealed by observation that there was a penetration in the firewall above the double doors leading into the North Gable Unit.	K 362	To meet the requirements of NFPA 101 (12) Life Safety Code Sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3 the penetration in the firewall above the double doors leading into the North Gable Unit will be sealed using the proper fire rated sealant system by 10/31/2024. The ESD will be responsible for ensuring this repair is completed promptly. The ESD or his proxy will review firewall penetrations after any wiring project is completed and hold contractors responsible for sealing any penetrations they create.	10/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	**5919 CENTERVILLE ROAD NORTH OAKS, MN 55127**

(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
K 362	Continued From page 8 An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 362		