DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: AO0V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245424**

2.STATE VENDOR OR MEDICAID NO.
(L2) **369842400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF ARDEN HILLS**
(L4) **3220 LAKE JOHANNA BOULEVARD**
(L5) **ARDEN HILLS, MN** (L6) **55112**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/02/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **208** (L18)

13.Total Certified Beds **208** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	208			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michelle Torrance, Health Laboratory 04/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Michaelyn Bruer, Enforcement Specialist 04/27/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On 02/15/2018 a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of G (F686). As a result of the survey findings, the Department is imposing the Category 1 remedy of State monitoring, effective 3/7/2017.

We also recommended:

DDPNA for deficiency cited at F686 effective May 5, 2018 (80 days).

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245424

April 27, 2018

Ms. Dori Mutch, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

Dear Ms. Mutch:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 31, 2018 the above facility is certified for or recommended for:

208 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 208 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 27, 2018

Ms. Dori Mutch, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: Project Number S5424027

Dear Ms. Mutch:

On March 2, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 7, 2018. (42 CFR 488.422)

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the imposed remedies in our letter dated March 2, 2018:

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective May 5, 2018. (42 CFR 488.417 (a))

This was based on the deficiencies cited by this Department for a standard survey completed on February 15, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 2, 2018, the Minnesota Departments of Health and Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 31, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2018, as of March 31, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 31, 2018.

In addition, this Department recommended to the CMS Region V Office the following action:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 5, 2018 be rescinded as of March 31, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 27, 2018

Ms. Dori Mutch, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

Re: Reinspection Results - Project Number S5424027

Dear Ms. Mutch:

On April 2, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 15, 2018. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: AO0V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245424**
2.STATE VENDOR OR MEDICAID NO.
(L2) **369842400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF ARDEN HILLS**
(L4) **3220 LAKE JOHANNA BOULEVARD**
(L5) **ARDEN HILLS, MN** (L6) **55112**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/15/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **208** (L18)
13.Total Certified Beds **208** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	208			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE NE II 03/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 03/26/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On 02/15/2018 a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of G (F686). As a result of the survey findings, the Department is imposing the Category 1 remedy of State monitoring, effective 3/7/2017.

We also recommended:

DDPNA for deficiency cited at F686 effective May 5, 2018 (80 days).

Electronically delivered

March 2, 2018

Ms. Dori Mutch, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: Project Number S5424027

Dear Ms. Mutch:

On February 15, 2018, a standard 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) as evidenced by the electronically delivered CMS-2567, whereby corrections are required. This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Appeal Rights - the facility rights to appeal imposed remedies;

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 7, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for

imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective May 5, 2018

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 5, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Presbyterian Homes Of Arden Hills is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 5, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for

its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 May 15, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 15, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

March 2, 2018

Ms. Dori Mutch, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: Project Number S5424027

Dear Ms. Mutch:

On February 15, 2018, a standard 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) as evidenced by the electronically delivered CMS-2567, whereby corrections are required. This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Appeal Rights - the facility rights to appeal imposed remedies;

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 7, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for

imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective May 5, 2018

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 5, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Presbyterian Homes Of Arden Hills is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 5, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for

its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 May 15, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 15, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF ARDEN HILLS	3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 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
F 000	INITIAL COMMENTS A recertification survey was conducted on 2/12, 2/13, 2/14 and 2/15/2018. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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. Your electronic submission of the POC will be used as verification of compliance	F 000		
F 623 SS=D	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.	F 623		3/23/18

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

Electronically Signed | 03/09/2018

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F 623	Continued From page 1 (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	F 623		

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F 623	Continued From page 2 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 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(l). This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to notify a representative of the	F 623	R141 has returned to the facility after her hospitalization which responsible party	

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F 623	Continued From page 3 Office of the State Long-Term Care Ombudsman when the facility initiated a hospital transfer for 1 of 3 residents (R141) reviewed for hospitalizations. Findings include: A visit progress note, dated 12/12/17, revealed the nurse practitioner saw R141 in the facility on 12/12/17. The nurse practitioner noted concerns over the past several months with cognitive decline, and escalating behaviors. According to the note, R141 was combative and verbally abusive during the visit. The nurse practitioner described R141 as being "unable to be redirected and behavior is progressive." The plan written on page five of the note was to admit R141 to a specialized hospital unit for evaluation and treatment, because medications were ineffective. Review of written physician orders revealed the nurse practitioner wrote an order on 12/12/17, to allow R141 to go to the specialized hospital unit to receive evaluation and treatment consultation for increasing behaviors that staff could not easily redirect. A progress note, dated 12/13/17, revealed the facility discharged R141 to the hospital at 12:05 p.m. with family consent, related to the nurse practitioner's order. A progress note, dated 1/2/18, revealed R141 readmitted to the facility around 10:30 a.m. from the hospital. On 2/15/18, at 2:22 p.m. records were requested regarding whether staff sent notification of the facility initiated hospital transfer to a	F 623	was in agreement with. The ombudsman was not notified of this transfer per facility protocol as it was identified as a “planned” transfer and not emergent in nature. The facility Discharge Policy and Procedure was reviewed and remains in effect. The facility bed hold policy was reviewed and updated. The facility bed hold policy is provided and reviewed with all new admissions and signed and saved in the medical record. It is the policy and practice that any planned hospitalization will have bed hold documented and reviewed upon to their transfer to reflect it is a non emergent transfer to the hospital. Under the policy, this is not considered a facility initiated transfer which would warrant notification of the State Ombudsman. All resident discharges and transfers that are facility initiated are logged and submitted to the Ombudsman following the transfer or discharge per facility policy. The facility has completed re-education of licensed Nurses and Resident Service Specialists regarding the updated policy and procedure. The facility will complete audits of all facility initiated transfers for appropriate documentation weekly for 4 weeks and monthly for 2 months to ensure ongoing compliance with notification of the State Ombudsman. The results of theses audits will be reviewed by the Quality Assurance team who will determine the need for further auditing. The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is 3/23/18.	

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F 623	Continued From page 4 representative of the Office of the State Long-Term Care Ombudsman (OOLTC). On 2/15/18, at 4:20 p.m. the administrator was unable to provide records of notification to the OOLTC. At 4:36 p.m. the administrator explained this was a planned facility initiated transfer to the hospital, because R141's behaviors had been escalating and ongoing, and the nurse practitioner witnessed the behaviors during a facility visit. The administrator confirmed that the facility had not sent notification of the hospital transfer to the OOLTC, because the corporate office had only been sending notification of unplanned, emergent transfers. The administrator was not aware that notification also needed to be sent to a representative from the OOLTC in the case of planned hospital transfers. Review of the Discharge Policy and Procedure, approved October 2017, defined Facility Initiated Discharge as the following: "a transfer or discharge which the resident representative did not initiate with a verbal or written request." The Discharge Policy and Procedure required the following for planned facility initiated discharges: "The facility will ensure that a notice is issued to the resident and the resident's representative within 30 days of the date of discharge. The facility must send a copy of this notice to the Office of the State Long Term Care Ombudsman at the same time as issuance to the resident."	F 623		
F 625 SS=D	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	F 625		3/23/18

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F 625	Continued From page 5 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 provide a written bed hold notice for 2 of 3 residents (R34, R141) reviewed for hospitalization. Findings include: R34 was transferred to the hospital on 2/8/18, and no written bed-hold notice was provided to the resident nor resident's representative. R34 was admitted to the facility on 4/3/15, with	F 625	R141 has returned to the facility and into her same room after her hospitalization which responsible party was in agreement with. The facility Discharge Policy and Procedure was reviewed and remains in effect. The facility bed hold policy was reviewed and updated. The facility bed hold policy is provided and reviewed with all new admissions and/or their responsible party and signed and saved in the medical record. The facility will	

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F 625	Continued From page 6 diagnosis including dementia with behavioral disturbance, major depressive disorder, unspecified mood disorder, brief psychotic disorder, chronic kidney disease,and hypertension (high blood pressure). Review of R34's progress note for 2/7/18, 17:19 indicated: "Resident sent to Unity Hospital Hospital ER (emergency room) by ambulance transport. Family notified. Bed hold obtained." No copy of written documentation of the bed hold was noted in R34's record. Interview with licensed practical nurse (LPN) -A on 2/15/18, at 2:11 p.m. indicated he was the staff who made the entry in the record after speaking with R34's daughter, but did not provide any written information to the resident nor resident's representative. R141 transferred to the hospital on 12/13/17, and was not provided written notice of bed hold. A progress note, dated 12/13/17, revealed the facility discharged R141 to the hospital at 12:05 p.m. A progress note, dated 12/29/17, revealed staff spoke with R141's daughter to discuss bed hold. On 2/15/18, at 5:10 p.m. a copy of R141's bed hold paperwork was requested. At 05:11 p.m. the director of nursing said the facility did not have a signed copy of the bed hold form for R141. Review of Presbyterian homes & services Bed Hold Policy modified November 2016, directed the following: When the facility transfers a resident to a hospital or a resident goes on therapeutic leave,	F 625	ensure that all residents who have a transfer will have a bed hold discussion completed and documented in the electronic medical record. Licensed Nurses and Resident Services Specialists have been trained on the revised Bed Hold Policy and the changes made. The facility will complete audits of 10% of residents to ensure documented bed hold upon admission and all transfers weekly for 4 weeks to ensure ongoing compliance with the bed hold policy. The results of theses audits will be reviewed by the Quality Assurance team who will determine the need for further auditing. The Resident Services Director or designee will be responsible for ongoing compliance; the date of compliance is 3/23/18.	

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F 625	Continued From page 7 the facility will provide written information of the bed hold policy to the resident and/or resident representative. Procedure: 1. Before a resident leaves for hospitalization or therapeutic leave, he/she is given a copy of the bed hold policy. A copy of the bed hold policy is preattached to the patient transfer form, which accompanies each resident. 3. The Nursing or Resident Services staff designee will contact the resident/responsible party to inquire about bed hold. If the resident/responsible part to inquire about bed hold. If the resident/responsible party chooses to pay bed hold, the agreement to pay changes form will be completed. 4. The completed bed hold signature form will be kept in the resident financial file.	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely check and change services for urinary incontinence for 1 of 3 residents (R101) reviewed with urinary incontinence and dependent upon staff for personal cares. Findings include: R101's Resident Face Sheet, indicated diagnoses including Alzheimer's disease with Dementia,	F 677	R 101 was provided assistance with hygiene and reposition upon identification. R101 has had a reassessment of her bowel and bladder function and skin risk to ensure an individualized plan for toileting assistance/incontinent needs and repositioning and her care sheet and care plan reflect an every 2 hour scheduled plan with incontinence care if needed. All residents are reviewed at daily IDT for change in status and care plans and care	3/23/18

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PRESBYTERIAN HOMES OF ARDEN HILLS	3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

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F 677	Continued From page 8 Type 2 Diabetes and Major depressive disorder. Document review of the facility form dated 12/21/17, titled, Brief Interview for Mental Status (BIMS) revealed R101 was severely impaired and the Care Area Assessment (CAA) addressed impaired communication due to severely impaired cognition secondary to late onset Alzheimer's disease. The CAA form dated 7/6/17, included incontinence of bowel and bladder. Always incontinent of bladder requiring staff assistance of one every three hours and p.m. (whenever necessary) for incontinent cares. The plan of care last revised 7/7/17, read, "I have functional bladder and bowel incontinence r/t severely impaired cognition with communication deficit and dependence on staff for incontinent cares 2' (secondary to) advanced late onset Alzheimer's disease. The intervention directed to check and change incontinent undergarment every 2-3 hours and prn (whenever necessary). The undated nursing assistant care sheet for toileting directed assist of 1 every two hours along with reposition every two hours. Pressure ulcer coccyx. Continuous observations were made of R101 on 2/12/18, from 12:00 p.m. until 3:28 p.m. and there was no offer of a check and change for incontinence care. At 12:00 p.m. R101 was seated at the dining room table waiting for lunch. At 1:00 p.m. nursing assistant (NA)-A sat with R101 to feed food and fluids. At 1:30 p.m. R101 was wheeled in the specialty chair to the day room for music therapy group activity. There were	F 677	sheets updated. All residents are assessed and reviewed for current ADL needs and necessary services upon admission, minimally quarterly and with significant change of condition and care plans and care sheets updated. Rounding of daily cares and services is conducted each shift by licensed nurses to ensure the appropriate cares and services is provided. Care sheets are reviewed as part of shift report and any changes communicated to applicable staff. Continuity of cares provided and timing of services due is communicated with shift change. The facility has reviewed the Skin Management Policy, Bowel and Bladder policy and care plan policy and they remain in effect. All nursing staff are receiving education on the assessment and development of the plan of care and the process to ensure the plan of care is being followed through the use of the care sheets and shift report. The facility will complete audits of 10% of residents care sheets and services provided weekly for 4 weeks to ensure ongoing compliance with cares and services. The results of theses audits will be reviewed by the Quality Assurance team who will determine the need for further auditing. The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is 3/23/18.	

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F 677	Continued From page 9	F 677		

no offers for a check and change for incontinence care. At 2:00 p.m. R101 was wheeled in the specialty chair to the dining room for cookie baking group activity. There were no offers for a check and change for incontinence care. At 3:00 p.m. R101 continued to sit at the cookie baking activity. At 3:12 p.m. R101 was moved to the day room to watch the Olympics on television. At 3:16 p.m. NA-B wheeled R101 to the bedroom for cares. NA-B was in and out of the bedroom to obtain supplies and the mechanical stand for the transfer. Registered nurse (RN)-C came to the room to assist with the transfer. At 3:28 p.m. the mechanical lift raised R101 off buttocks into a standing position.

Observations continued on 2/12/18, and at 3:37 p.m. NA-B and RN-C turned R101 to the side to remove the incontinence brief and visualize the buttocks and posterior thighs. There was a four by three circular dressing with clear tape borders at the coccyx and right buttocks which extended to the left buttock. Under the clear tape dressing extending to the left buttocks was a new red moist open area that measured 4.0 cm length by 1.4 cm width. RN-C removed the dressing from the coccyx which revealed a unstageable pressure ulcer approximately 4 cm by 2 cm. There were multiple red creases/craters and wrinkling of the skin to the buttocks and posterior thigh areas on R101.

When interviewed on 2/12/18, at 4:00 p.m. nursing assistant (NA)-B verified not knowing what time the day shift completed a check and change for incontinence care. Furthermore, NA-B verified R101 should have been in bed by 2:30 p.m. but the time got away from NA-B.

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F 677	Continued From page 10 The Skin Integrity Management Policy dated revised 1/2017, indicated under the Care Plan, read, "The results of the comprehensive assessment are used to develop, review and revise resident's comprehensive plan of care. Based upon the findings of the clinical assessment in partnership with the resident and / or family input, a care plan will be developed or modified to reflect alterations in interventions and implementation of new interventions specific to the resident. The care planned interventions will get communicated to the appropriate staff via the nursing assistant assignment sheet or My Best Day and /or through report. Skin Protection addressed to assess and treat incontinence. When incontinence cannot be controlled, use appropriate-care with barrier cream to perineal area after each episode of incontinence. During an interview with registered nurse (RN)-C on 2/14/18, at 8:30 a.m. verified inability to determine from the day shift what time R101 was toileted prior to surveyor observations on 2/12/17 from 12:00 p.m. through 3:30 p.m.. Furthermore RN-C verified the plan of care should have been updated to reflect R101 had a pressure ulcer on the coccyx and the toileting check and change should have reflected to be performed every two hours.	F 677		
F 686 SS=G	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	F 686		3/23/18

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F 686	Continued From page 11 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they 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 document review, the facility failed to implement consistent monitoring and evaluation of an open area on the coccyx to prevent further skin breakdown and failed to provide timely repositioning for 1 of 3 residents (R101) reviewed with pressure ulcers. The failure of the facility to monitor the open area on the coccyx resulted in the deterioration and identification of an unstageable deep tissue injury, which resulted in harm for R101, who was not provided timely repositioning and incontinent cares and experienced a newly acquired Stage 2 pressure ulcer. Findings include: R101 did not receive a position change on 2/12/18, for three hours and twenty-eight minutes (3 hrs, 28 min) and acquired a new Stage 2 open area, length 4.0 centimeter (cm) by width 1.4 cm size to the left mid buttock. An open slit in the coccyx was identified on 1/18/18; documentation was lacking to indicate the skin condition had been monitored and evaluated until 1/29/18, when an unstageable deep tissue injury was identified. R101 currently has an unstageable (Full thickness skin and tissue loss in which the extent of the tissue damage cannot be confirmed because it is obscured by slough or eschar. If	F 686	R101 was provided immediate care upon identification and physician notified. R101 has had a Skin Risk and Braden assessment completed on 2/21/18 to ensure that she has been comprehensively assessed, and that her plan of care and care sheets match the individualized needs identified on the assessment. The Stage II Pressure Injury that was referenced on the left buttocks resolved as healed on 2/19/18. The Unstageable Pressure Injury on the right side of the buttocks continues to be treated with physician ordered wound care and monitored weekly by licensed nursing staff. All residents with pressure injuries have had their Comprehensive Skin Risk and Braden assessment reviewed to ensure this assessment reflects their current needs, and that the assessment matches the care plan and care sheet and is being followed. In addition all resident with current pressure injuries have been reviewed to ensure their primary care provider has been updated with the current status of these wounds and that this is documented. All residents without current skin issues will have their	

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F 686	Continued From page 12 slough or eschar is removed, a stage 3 or stage 4 pressure ulcer/injury will be revealed.) deep tissue injury area measuring 6.5 cm, length 4.7 cm, width 1.7 cm, to the coccyx/right buttock area. Continuous observations were made of R101 on 2/12/18, from 12:00 p.m. until 3:28 p.m. and there was no offer of a position change. At 12:00 p.m. R101 was seated at the dining room table waiting for lunch. At 1:00 p.m. nursing assistant (NA)-A sat with R101 to feed food and fluids. At 1:30 p.m. R101 was wheeled in the specialty chair to the day room for music therapy group activity. There were no offers for a position change, R101 remained in the same position. At 2:00 p.m. R101 was wheeled in the specialty chair into the dining room for cookie baking group activity. There were no offers for a position change. At 3:00 p.m. R101 continued to sit at the cookie baking activity. At 3:12 p.m. R101 was transported to the day room to watch the Olympics on television. At 3:16 p.m. NA-B wheeled R101 to the bedroom for cares. NA-B was in and out of the bedroom to obtain supplies and the mechanical stand for the transfer. Registered nurse (RN)-C entered the room to assist with the transfer. At 3:28 p.m. the mechanical lift raised R101 off buttocks into a standing position. Observations continued on 2/12/18, and at 3:37 p.m. when NA-B and RN-C turned R101 onto the side to visualize the buttocks and posterior thighs. There was a four by three circular dressing with clear tape borders at the coccyx and right buttocks which extended to the left buttock. Under the clear tape dressing extending to the left buttocks was a new red moist open area that	F 686	Comprehensive Skin Risk and Braden assessments completed and care plans reviewed through the RAI process and as needed. The facility has reviewed the Skin Management Policy and it remains in effect. All nursing staff are receiving education on assessing for skin risk for pressure injury development to develop the plan of care for repositioning, and weekly skin body audit and which is communicated through the care strips (nursing assistant care sheets). Licensed Nurses have also received education on wound care. The facility will complete audits of 10% of residents weekly for 4 weeks to ensure ongoing compliance with provision of care to prevent pressure injury development, and provision of care when skin issues do develop. The results of theses audits will be reviewed by the Quality Assurance team who will determine the need for further auditing. The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is 3/23/18.	

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measured 4.0 cm length by 1.4 cm width. RN-C removed the dressing from the coccyx which revealed a unstageable pressure ulcer approximately 4 cm by 2 cm. There were multiple red creases/craters and wrinkling of the skin to the buttocks and posterior thigh areas on R101. At 3:55 p.m. RN-D came to the room with supplies and to assist with wound care and assessment.

When interviewed on 2/12/18, at 3:00 p.m. RN-D verified she saw the left buttocks with a red area and confirmed it had not been open like it was at this time. RN-C verified applying the dressing to the wound in the a.m. on 2/12/18, and knew the dressing was too small to cover the entire area but it was all that was available. RN-C verified the tape from the dressing could have contributed to the Stage 2 pressure ulcer noted on the left buttock as well the failure to provide a position change every two hours according to the plan of care.

When interviewed on 2/12/18, at 4:00 p.m. nursing assistant (NA)-B verified not knowing what time the day shift completed the repositioning care. Furthermore, NA-B verified R101 should have been in bed by 2:30 p.m. but the time got away from NA-B.

R101's Resident Face Sheet, indicated diagnoses including Alzheimer's disease with Dementia, Type 2 Diabetes and Major depressive disorder. Document review of the facility form titled Brief Interview for Mental Status (BIMS) revealed R101 was severely impaired and the Care Area Assessment (CAA) addressed impaired communication due to severely impaired cognition secondary to late onset Alzheimer's

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F 686	Continued From page 14	F 686		

disease.

The CAA form dated 7/6/17, included pressure ulcer risk due to total assist with all mobility, always incontinent, non ambulatory and a mechanical lift with all transfers. The skin assessment titled Skin Risk and Braden, dated 12/16/17, indicated R101 was at moderate risk to develop pressure ulcers and had an open wound to the right buttock and scar tissue on the left buttock. Repositioning was to occur every two to three hours.

Document review of the progress notes dated 12/27/17, indicated the open area to the right buttock was dermatitis related. The left buttock area was closed. On 1/18/18, the progress notes indicated the "open area in slit of buttock measuring 2 x 0.5 cm and 0.7 x 0.2 cm." Interventions included: applied barrier cream and offload per care plan. There are no progress notes from 1/18/18 until 1/29/19 related to measurements, evaluation and/or wound treatment. No ongoing monitoring of the skin condition was available for review. No mention of the open area was documented until the progress note dated 1/29/19, which read, "Resident has a pressure injury. Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration." Referring to the wound on the coccyx. The document titled, Skin and Wound dated 1/29/18, identified the wound measurements to the coccyx area as: 6.5 cm, length 4.7 cm, width 1.7 cm with slough, 30% of wound filled, eschar 40% of wound filled, surrounding tissue fragile skin that is at risk for breakdown.

Review of the progress notes dated 2/12/18, at

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F 686	Continued From page 15	F 686		

4:57 p.m. documented by RN-C read, "Resident has a pressure injury. Stage 2: Partial-thickness skin loss with exposed dermis. Practitioner notified. Resident/responsible party notified. Dietitian notified." The document titled, Skin and Wound-Wound Assessment, dated 2/12/18, indicated a new Stage 2 pressure ulcer acquired in house to the left buttock. Wound measurement area 3.9 cm, length 4.0 cm, width 1.4 cm, depth 0 cm. with surrounding tissue erythema: redness of the skin- may be intense bright red to dark red or purple.

Document review of the plan of care dated 2/8/18, for skin integrity addressed recurring open area to buttocks related to moisture/incontinence pressure ulcer to coccyx and the intervention addressed wheel chair cushion, air mattress, and repositioning schedule every two hours and prn (whenever necessary). The untitled document staff refer to as the nursing assistant care sheet dated 2/12/18, for repositioning directed staff to reposition every two hours and to lay down in bed at 2:30 p.m. for a 45 minute to 1 hour nap.

Document review of the nurse practitioner (NP) notes dated 1/17/18, titled Follow Up Visit, addressed skin as no rash, ulceration or suspicious lesion. A subsequent NP note dated 1/25/18, titled Follow Up Visit, addressed skin as no rash, ulceration or suspicious lesion. It was not until the 2/7/18, during a follow up visit that the NP addressed the coccyx wound and indicated it was reported on 1/29/18. On 2/7/18, the NP documented in the Follow Up Visit, Skin: has a Unstageable coccyx ulcer. New physician order dated 2/7/18, indicated: start Santyl- (ointment to debride dermal ulcers) apply to wound bed daily and cover with Tegaderm foam dressing.

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F 686	Continued From page 16 When interviewed on 2/15/18, at 11:07 a.m. the NP verified she had not addressed the skin issues in the progress notes and stated, "I thought the area was dermatitis related, which comes and goes." The NP verified being unaware of the actual open area to the coccyx until addressed on 1/18/18, as an open slit of buttock measuring 2 x 0.5 cm and 0.7 x 0.2 cm area. After completion of the wound assessment on 1/29/18 (11 days later), an unstageable deep tissue injury was identified. The NP verified the expectation would be that nursing staff provide weekly updates and typically would follow through every week but did not realize eleven days had elapsed without a wound assessment nor a physician notification. Furthermore, the NP verified she was unaware of the severity of the coccyx wound until 1/29/18, and did not address any skin issues nor examine the coccyx area on 1/17/18 nor 1/25/18, during follow up visits. Document review of the 1/2017 policy titled, Skin Integrity Management Policy, directed, "Documentation on the wound using the Wound Assessment with a structured progress note generating from the assessment should be done at least weekly, or more frequently depending on the wound characteristics or type dressing used." When interviewed on 2/15/18, at 3:00 p.m. the director of nursing verified the facility expectation would be to evaluate the wounds weekly ensuring the physician was well informed and to follow the interventions especially for re-positioning in [R101] situation of every two hours.	F 686		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		3/23/18

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F 756	Continued From page 17 §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		

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F 756	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to follow up on the consultant pharmacist's recommendation for monitoring psychotropic medications for 1 of 5 residents (R72) reviewed for psychotropic medications. Findings include: A review of R72's physician orders revealed R72 had an order for the antipsychotic medication Seroquel. Physician orders indicated Seroquel (Quetiapine Fumarate) 75 milligrams (mg) was to be administered one time a day for delirium. Review of R72's monthly pharmacist recommendations dated 9/22/17, included clarification of quetiapine indication and consideration of a quetiapine gdr (gradual dose reduction). Review of the Consultant Pharmacist Communication to Physician dated 9/22/17, indicated: "1. Her quetiapine order in PCC indicates that she is taking this for delirium. She has not had delirium symptoms/behavioral concerns noted in her recent charting. Is this still an appropriate indication?" R72's care plan included use of antipsychotic medication related to delirium and interventions included monitor/document for side effects and target behaviors. Review of R72's behavior monitoring for February did not indicate any monitoring was being done for delirium.	F 756	R72 had a dose reduction on 2/15/18, provider decreased her Quetiapine again as no symptoms of delirium or delusions have been noted. The facility added monitoring of delusions and delirium each shift for ongoing evaluation of her condition. Facility and provider are continuing to monitor her for delusions and delirium. All residents are assessed for GDR per facility policy. All residents of Johanna Shores have been reviewed to ensure appropriate behavior monitoring, side effect monitoring, and GDR's completed per Pharmacist recommendations. The policy and procedure for Psychotropic and Unnecessary Medications was reviewed and policy remains current. Education provided to staff related to behavior monitoring, side effect monitoring, and GDR's reviewed and handling Pharmacy recommendations. The facility will complete audits for 10% of the residents receiving psychotropic medications weekly for 4 weeks to ensure ongoing compliance with psychotropic drug use. The results of theses audits will be reviewed by the Quality Assurance team who will determine the need for further auditing. The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is 3/23/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	02/15/2018

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F 756	Continued From page 19 On 2/15/18, at 10:42 a.m. registered nurse (RN)-E indicated per pharmacist recommendation on 9/29/17, Seroquel was decreased to 75 mg. RN-E indicated anytime there was a medication dosage decrease, we order daily monitoring and are looking for evidence of delusions. RN-E further indicated there were no specific notes documenting delusions and would update the provider. On 2/15/18, at 11:36 a.m. RN-E indicated she had spoken with the consultant pharmacist who confirmed staff should be monitoring R72's behavior for delusions. On 2/15/18, at 4:21 p.m. the clinical administrator indicated behavior monitoring should be included with antipsychotic medications, side effect monitoring as well, and this should be care planned also. The Psychotropic and Unnecessary Medication Use Policy dated September 2017 indicated: "1. Specific target behaviors will be monitored for psychotropic medications."	F 756		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g)	F 791		3/23/18

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F 791	Continued From page 20 of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain routine dental services for 1 of 2 residents (R157) identified with dental issues and receiving Medicaid services.	F 791	R157 was seen on 2/19/18 by the Apple Tree dental hygienist. Recommendations include routine dental referral needed but resident has non-urgent dental care needs, R157 is scheduled to be seen by	

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F 791	Continued From page 21 Findings include: On 2/13/18, at 12:27 p.m. R157 was observed with multiple missing and a single front tooth on the upper gum line, and some missing teeth on the lower gum line. On 2/14/18, at 8:38 a.m. hospice aide (HA)-B stated R157 could be resistive to oral cares. HA-B showed the surveyor an undated computerized hospice care plan indicating R157 was resistive to oral cares and had poor teeth. An Oral/Dental Assessment dated 9/12/17, indicated that while R157 would not allow the dental hygienist (DH) to look in the mouth, R157 stated her teeth were bad and requested to see a dentist. The DH documented on the assessment that a routine dental referral was made, noting the need to see the dentist was not urgent. The care plan developed 3/13/17, directed staff to coordinate arrangements for dental care, transportation as needed/as ordered. A revision to the care plan dated 8/8/17, revealed R157 was at risk for oral/dental health problems related to refusal of cares at times. This revision also noted R157 had natural teeth and an upper partial was not worn. Review of the medical record revealed R157's request to see a dentist and the dental referral had not been followed upon. There was no documentation found indicating R157 had seen the dentist since being seen by the DH on 9/12/17. On 2/14/18, at 10:14 a.m. registered nurse (RN)-A provided a document titled, Oral Health	F 791	the Dentist the week of 3/19/18. The facility has reviewed all residents to ensure that all dental needs have been met as directed by the dental screen. The facility policy and procedure were reviewed for dental referrals and it remains in effect. The facility has completed education to all nursing and Health Information staff on the process for managing dental referrals to ensure timely follow up. The facility will complete audits for needed dental services weekly for 4 weeks to ensure ongoing compliance with follow up to dental referrals. The results of theses audits will be reviewed by the Quality Assurance team who will determine the need for further auditing. The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is 3/23/18.	

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F 791	Continued From page 22 Plan & Consent Form signed by R157 on 2/22/17. The consent form indicated R157 planned to refuse all oral health services "unless she has a need." RN-A did not know why R157's and the DH's dentist referral of 9/12/17, had not been followed up on. A copy of a facility policy regarding dental services was requested, but not received from the facility.	F 791		
F 880 SS=E	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 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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		3/23/18

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F 880	Continued From page 23 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 (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.	F 880		

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F 880	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the failed to ensure proper infection control practices were followed for 7 of 27 residents (R21, R41, R60, R102, R125, R156, R177) equipment reviewed for infection control. Findings include: On 2/14/18 at 2:29 p.m., nursing assistant (NA)-C was observed returning a Hoyer Lift to the storage area where another Hoyer Lift was already stored. NA-C had gloves on and proceeded to clean each lift with a disinfectant wipe. NA-C indicated each lift was cleaned between resident use. NA-C walked over to the medication cart, pointed to a container of blue top disinfectant wipes, and indicated he used those to clean the lifts. The blue top container safety data sheet dated 4/1/15, indicated product identifier: Sani-Hands Instant Hand Sanitizing Wipes with recommended use as an antiseptic. The purple top container safety data sheet dated 10/25/15, indicated product name: Super Sani-cloth Germicidal Wipe with recommended use as a disinfectant on hard, non-porous surfaces. On 2/15/18 at 8:08 a.m., the clinical administrator indicated when Hoyer lifts are soiled staff should disinfect them with Sani-wipes from purple top containers. Mechanical Lift Transfer Policy dated 2/2016 indicated: "18. Lifts should be cleaned when	F 880	The infection control policy and procedure was reviewed and is current. It is the policy of Johanna Shores that Mechanical Lifts are cleaned on a routine basis by Environmental Services, and are cleaned as needed, when visibly soiled between the routine cleanings. Education was completed with nursing and environmental services staff on the policy and will include appropriate disinfectant use. The facility will complete audits of infection control practices, including lift cleaning for 4 weeks to ensure ongoing compliance with infection control. The results of theses audits will be reviewed by the Quality Assurance team who will determine the need for further auditing. The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is 3/23/18.	

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F 880	Continued From page 25 soiled as needed and on a routine cleaning schedule." Infection Prevention and Control Manual General Policy dated 2017 indicated: "6. All items, other than disposables, are cleaned, disinfected, or sterilized, following federal, state and local guidelines and manufacturers recommendations. 7. Use of disinfectants, antiseptics, and germicides are by manufacturers' instructions and EPA or FDA label specifications to avoid harm to staff, residents and visitors and to ensure effectiveness."	F 880		

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	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2018**

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2018

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Presbyterian Home of Arden Hills is a 4-story building with a full basement. The building was constructed at 2 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. separate buildings. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 208 beds and had a census of 187 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101	K 223		3/31/18

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K 223	Continued From page 2 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code(19.2.2.2.7, 19.2.2.2.8) This deficient practice could affect the safety of all (187) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/13/18, observations and staff interview revealed the following: Basement mattress storage room needs a self closing device located on the door. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 223	An approved self closing device will be installed on the basement mattress storage room to make the door meet the requirements of the 2012 NFPA 101 Life Safety code. This device will be installed by March 31st, 2018. The Environmental Services Director (ESD) will be responsible for ensuring this device is installed and inspected per requirements in the life safety code.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101	K 291		3/31/18

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K 291	Continued From page 3 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: The facility failed to comply with Life Safety Code (7.9.18.2.9.1, 19.2.9.1) This deficient practice could affect the safety of all (178) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/13/2018, revealed the following: 1. Observation during the inspection found facility was not testing emergency light in Generator room. 2. Observation during the inspection found facility need an emergency back-up light unit installed outside of generator room. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	The emergency battery powered light in the generator room will be tested as required by the 2012 NFPA 101 Life Safety Code. This routine will be entered by the ESD in the electronic work order system as a preventative maintenance work order to ensure the requirements are met. This routine will be entered into the work order system by March 31st, 2018 A battery powered emergency back up light will be installed outside the generator room as required by the 2012 NFPA 101 Life Safety Code by March 31st, 2018. The ESD will be responsible for ensuring this light is properly installed and maintained	
K 343 SS=D	Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient.	K 343		3/31/18

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K 343	Continued From page 4 The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)) This deficient practice could affect the safety of all (178) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/13/18, observations and staff interview revealed the following: We found basement mattress room needs a smoke detector installed as room is now a storage room. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 343	A smoke detector will be installed in the basement mattress storage room as required by the 2012 NFPA 101 Life Safety Code by March 31st. The ESD will be responsible for ensuring this smoke detector is properly installed and maintained.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 911		3/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF ARDEN HILLS	**3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112**

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K 911	Continued From page 5 The facility failed to comply with Life Safety Code (Chapter 6 (NFPA 99) This deficient practice could affect the safety of all (16) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/13/18, observations and staff interview revealed the following: We found electric boxes missing cover plated above the smoke barrier by room 316 and 221. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 911	Cover plates will be installed on the two junction boxes above the smoke barrier by room 316 and 221 as required by the 2012 NFPA 101 Life Safety Code. The ESD will be responsible to ensure these covers are properly installed by March 31st, 2018. The ESD will be responsible for ensuring that there are no unsealed penetrations in smoke barrier walls.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 2, 2018

Ms. Dori Mutch, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

Re: State Nursing Home Licensing Orders - Project Number S5424027

Dear Ms. Mutch:

The above facility was surveyed on February 12, 2018 through February 15, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 contact Susie Haben, Unit Supervisor at (651) 201-2731 or at susie.haben@state.mn.us.

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00975	A. BUILDING: _____ B. WING _____	02/15/2018

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PRESBYTERIAN HOMES OF ARDEN HILLS	3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On February 12, 13, 14, 15, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement consistent monitoring and evaluation of an open area on the coccyx to prevent further skin breakdown and failed to provide timely repositioning for 1 of 3 residents (R101) reviewed with pressure ulcers. The failure of the facility to monitor the open area on the coccyx resulted in the deterioration and identification of an unstageable deep tissue injury, which resulted in harm for R101, who was not provided timely repositioning and incontinent	2 900	Corrected	3/23/18

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2 900	Continued From page 3 cares and experienced a newly acquired Stage 2 pressure ulcer. Findings include: R101 did not receive a position change on 2/12/18, for three hours and twenty-eight minutes (3 hrs, 28 min) and acquired a new Stage 2 open area, length 4.0 centimeter (cm) by width 1.4 cm size to the left mid buttock. An open slit in the coccyx was identified on 1/18/18; documentation was lacking to indicate the skin condition had been monitored and evaluated until 1/29/18, when an unstageable deep tissue injury was identified. R101 currently has an unstageable (Full thickness skin and tissue loss in which the extent of the tissue damage cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a stage 3 or stage 4 pressure ulcer/injury will be revealed.) deep tissue injury area measuring 6.5 cm length, 4.7 cm width, 1.7 cm width, to the coccyx/right buttock area. Continuous observations were made of R101 on 2/12/18, from 12:00 p.m. until 3:28 p.m. and there was no offer of a position change. At 12:00 p.m. R101 was seated at the dining room table waiting for lunch. At 1:00 p.m. nursing assistant (NA)-A sat with R101 to feed food and fluids. At 1:30 p.m. R101 was wheeled in the specialty chair to the day room for music therapy group activity. There were no offers for a position change, R101 remained in the same position. At 2:00 p.m. R101 was wheeled in the specialty chair into the dining room for cookie baking group activity. There were no offers for a position change. At 3:00 p.m. R101 continued to sit at the cookie baking activity. At 3:12 p.m. R101 was transported to the day room to watch the	2 900		

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2 900	Continued From page 4 Olympics on television. At 3:16 p.m. NA-B wheeled R101 to the bedroom for cares. NA-B was in and out of the bedroom to obtain supplies and the mechanical stand for the transfer. Registered nurse (RN)-C entered the room to assist with the transfer. At 3:28 p.m. the mechanical lift raised R101 off buttocks into a standing position. Observations continued on 2/12/18, and at 3:37 p.m. when NA-B and RN-C turned R101 onto the side to visualize the buttocks and posterior thighs. There was a four by three circular dressing with clear tape borders at the coccyx and right buttocks which extended to the left buttock. Under the clear tape dressing extending to the left buttocks was a new red moist open area that measured 4.0 cm length by 1.4 cm width. RN-C removed the dressing from the coccyx which revealed a unstageable pressure ulcer approximately 4 cm by 2 cm. There were multiple red creases/craters and wrinkling of the skin to the buttocks and posterior thigh areas on R101. At 3:55 p.m. RN-D came to the room with supplies and to assist with wound care and assessment. When interviewed on 2/12/18, at 3:00 p.m. RN-D verified she saw the left buttocks with a red area and confirmed it had not been open like it was at this time. RN-C verified applying the dressing to the wound in the a.m. on 2/12/18, and knew the dressing was too small to cover the entire area but it was all that was available. RN-C verified the tape from the dressing could have contributed to the Stage 2 pressure ulcer noted on the left buttock as well the failure to provide a position change every two hours according to the plan of care.	2 900		

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2 900	Continued From page 5 When interviewed on 2/12/18, at 4:00 p.m. nursing assistant (NA)-B verified not knowing what time the day shift completed the repositioning care. Furthermore, NA-B verified R101 should have been in bed by 2:30 p.m. but the time got away from NA-B. R101's Resident Face Sheet, indicated diagnoses including Alzheimer's disease with Dementia, Type 2 Diabetes and Major depressive disorder. Document review of the facility form titled Brief Interview for Mental Status (BIMS) revealed R101 was severely impaired and the Care Area Assessment (CAA) addressed impaired communication due to severely impaired cognition secondary to late onset Alzheimer's disease. The CAA form dated 7/6/17, included pressure ulcer risk due to total assist with all mobility, always incontinent, non ambulatory and a mechanical lit with all transfers. The skin assessment titled Skin Risk and Braden, dated 12/16/17, indicated R101 was at moderate risk to develop pressure ulcers and had an open wound to the right buttock and scar tissue on the left buttock. Repositioning was to occur every two to three hours. Document review of the progress notes dated 12/27/17, indicated the open area to the right buttock was dermatitis related. The left buttock area was closed. On 1/18/18, the progress notes indicated the "open area in slit of buttock measuring 2 x 0.5 cm and 0.7 x 0.2 cm." Interventions included: applied barrier cream and offload per care plan. There are no progress notes from 1/18/18 until 1/29/19 related to measurements, evaluation and/or wound treatment. No ongoing monitoring of the skin	2 900		

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2 900	Continued From page 6	2 900		

condition was available for review. No mention of the open area was documented until the progress note dated 1/29/19, which read, "Resident has a pressure injury. Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration." Referring to the wound on the coccyx. The document titled, Skin and Wound dated 1/29/18, identified the wound measurements to the coccyx area as: 6.5 cm, length 4.7 cm, width 1.7 cm with slough, 30% of wound filled, eschar 40% of wound filled, surrounding tissue fragile skin that is at risk for breakdown.

Review of the progress notes dated 2/12/18, at 4:57 p.m. documented by RN-C read, "Resident has a pressure injury. Stage 2: Partial-thickness skin loss with exposed dermis. Practitioner notified. Resident/responsible party notified. Dietitian notified." The document titled, Skin and Wound-Wound Assessment, dated 2/12/18, indicated a new Stage 2 pressure ulcer acquired in house to the left buttock. Wound measurement area 3.9 cm, length 4.0 cm, width 1.4 cm, depth 0 cm. with surrounding tissue erythema: redness of the skin- may be intense bright red to dark red or purple.

Document review of the plan of care dated 2/8/18, for skin integrity addressed recurring open area to buttocks related to moisture/incontinence pressure ulcer to coccyx and the intervention addressed wheel chair cushion, air mattress, and repositioning schedule every two hours and prn (whenever necessary). The untitled document staff refer to as the nursing assistant care sheet dated 2/12/18, for repositioning directed staff to reposition every two hours and to lay down in bed at 2:30 p.m. for a 45 minute to 1 hour nap.

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2 900	Continued From page 7 Document review of the nurse practitioner (NP) notes dated 1/17/18, titled Follow Up Visit, addressed skin as no rash, ulceration or suspicious lesion. A subsequent NP note dated 1/25/18, titled Follow Up Visit, addressed skin as no rash, ulceration or suspicious lesion. It was not until the 2/7/18, during a follow up visit that the NP addressed the coccyx wound and indicated it was reported on 1/29/18. On 2/7/18, the NP documented in the Follow Up Visit, Skin: has a Unstageable coccyx ulcer. New physician order dated 2/7/18, indicated: start Santyl- (ointment to debride dermal ulcers) apply to wound bed daily and cover with Tegaderm foam dressing. When interviewed on 2/15/18, at 11:07 a.m. the NP verified she had not addressed the skin issues in the progress notes and stated, "I thought the area was dermatitis related, which comes and goes." The NP verified being unaware of the actual open area to the coccyx until addressed on 1/18/18, as an open slit of buttock measuring 2 x 0.5 cm and 0.7 x 0.2 cm area. After completion of the wound assessment on 1/29/18 (11 days later), an unstageable deep tissue injury was identified. The NP verified the expectation would be that nursing staff provide weekly updates and typically would follow through every week but did not realize eleven days had elapsed without a wound assessment nor a physician notification. Furthermore, the NP verified she was unaware of the severity of the coccyx wound until 1/29/18, and did not address any skin issues nor examine the coccyx area on 1/17/18 nor 1/25/18, during follow up visits. Document review of the 1/2017 policy titled, Skin Integrity Management Policy, directed, "Documentation on the wound using the Wound Assessment with a structured progress note	2 900		

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2 900	Continued From page 8 generating from the assessment should be done at least weekly, or more frequently depending on the wound characteristics or type dressing used." When interviewed on 2/15/18, at 3:00 p.m. the director of nursing verified the facility expectation would be to evaluate the wounds weekly ensuring the physician was well informed and to follow the interventions especially for re-positioning in [R101] situation of every two hours. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could 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, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.	2 905		3/23/18

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2 905	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 3 residents (R101) reviewed with pressure ulcers. Findings include: Continuous observations were made of R101 on 2/12/18, from 12:00 p.m. until 3:28 p.m. and there was no offer of a position change. At 12:00 p.m. R101 was seated at the dining room table waiting for lunch. At 1:00 p.m. nursing assistant (NA)-A sat with R101 to feed food and fluids. At 1:30 p.m. R101 was wheeled in the specialty chair to the day room for music therapy group activity. There were no offers for a position change, R101 remained in the same position. At 2:00 p.m. R101 was wheeled in the specialty chair into the dining room for cookie baking group activity. There were no offers for a position change. At 3:00 p.m. R101 continued to sit at the cookie baking activity. At 3:12 p.m. R101 was transported to the day room to watch the Olympics on television. At 3:16 p.m. NA-B wheeled R101 to the bedroom for cares. NA-B was in and out of the bedroom to obtain supplies and the mechanical stand for the transfer. Registered nurse (RN)-C entered the room to assist with the transfer. At 3:28 p.m. the mechanical lift raised R101 off buttocks into a standing position. Observations continued on 2/12/18, and at 3:37 p.m. when NA-B and RN-C turned R101 onto the side to visualize the buttocks and posterior thighs. There was a four by three circular dressing with clear tape borders at the coccyx and right buttocks which extended to the left buttock.	2 905	Corrected	

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2 905	Continued From page 10	2 905		

Under the clear tape dressing extending to the left buttocks was a new red moist open area that measured 4.0 cm length by 1.4 cm width. RN-C removed the dressing from the coccyx which revealed a unstageable pressure ulcer approximately 4 cm by 2 cm. There were multiple red creases/craters and wrinkling of the skin to the buttocks and posterior thigh areas on R101. At 3:55 p.m. RN-D came to the room with supplies and to assist with wound care and assessment.

When interviewed on 2/12/18, at 3:00 p.m. RN-D verified she saw the left buttocks with a red area and confirmed it had not been open like it was at this time. RN-C verified applying the dressing to the wound in the a.m. on 2/12/18, and knew the dressing was too small to cover the entire area but it was all that was available. RN-C verified the tape from the dressing could have contributed to the Stage 2 pressure ulcer noted on the left buttock as well the failure to provide a position change every two hours according to the plan of care.

When interviewed on 2/12/18, at 4:00 p.m. nursing assistant (NA)-B verified not knowing what time the day shift completed the repositioning care. Furthermore, NA-B verified R101 should have been in bed by 2:30 p.m. but the time got away from NA-B.

R101's Resident Face Sheet, indicated diagnoses including Alzheimer's disease with Dementia, Type 2 Diabetes and Major depressive disorder. Document review of the facility form titled Brief Interview for Mental Status (BIMS) revealed R101 was severely impaired and the Care Area Assessment (CAA) addressed impaired communication due to severely impaired

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2 905	Continued From page 11 cognition secondary to late onset Alzheimer's disease. The CAA form dated 7/6/17, included pressure ulcer risk due to total assist with all mobility, always incontinent, non ambulatory and a mechanical lit with all transfers. The skin assessment titled Skin Risk and Braden, dated 12/16/17, indicated R101 was at moderate risk to develop pressure ulcers and had an open wound to the right buttock and scar tissue on the left buttock. Repositioning was to occur every two to three hours. Document review of the progress notes dated 12/27/17, indicated the open area to the right buttock was dermatitis related. The left buttock area was closed. On 1/18/18, the progress notes indicated the "open area in slit of buttock measuring 2 x 0.5 cm and 0.7 x 0.2 cm." Interventions included: applied barrier cream and offload per care plan. There are no progress notes from 1/18/18 until 1/29/19 related to measurements, evaluation and/or wound treatment. No ongoing monitoring of the skin condition was available for review. No mention of the open area was documented until the progress note dated 1/29/19, which read, "Resident has a pressure injury. Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration." Referring to the wound on the coccyx. The document titled, Skin and Wound dated 1/29/18, identified the wound measurements to the coccyx area as: 6.5 cm, length 4.7 cm, width 1.7 cm with slough, 30% of wound filled, eschar 40% of wound filled, surrounding tissue fragile skin that is at risk for breakdown. Review of the progress notes dated 2/12/18, at	2 905		

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2 905	Continued From page 12 4:57 p.m. documented by RN-C read, "Resident has a pressure injury. Stage 2: Partial-thickness skin loss with exposed dermis. Practitioner notified. Resident/responsible party notified. Dietitian notified." The document titled, Skin and Wound-Wound Assessment, dated 2/12/18, indicated a new Stage 2 pressure ulcer acquired in house to the left buttock. Wound measurement area 3.9 cm, length 4.0 cm, width 1.4 cm, depth 0 cm. with surrounding tissue erythema: redness of the skin- may be intense bright red to dark red or purple. Document review of the plan of care dated 2/8/18, for skin integrity addressed recurring open area to buttocks related to moisture/incontinence pressure ulcer to coccyx and the intervention addressed wheel chair cushion, air mattress, and repositioning schedule every two hours and prn (whenever necessary). The untitled document staff refer to as the nursing assistant care sheet dated 2/12/18, for repositioning directed staff to reposition every two hours and to lay down in bed at 2:30 p.m. for a 45 minute to 1 hour nap. When interviewed on 2/15/18, at 3:00 p.m. the director of nursing verified the facility expectation would be to follow the interventions especially for re-positioning in [R101] situation of every two hours. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff on the importance of timely repositioning. Periodic audits could be conducted to ensure compliance and the results of such audits could be reviewed during the quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		

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2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely check and change services for urinary incontinence for 1 of 3 residents (R101) reviewed with urinary incontinence and dependent upon staff for personal cares. Findings include: R101's Resident Face Sheet, indicated diagnoses including Alzheimer's disease with Dementia, Type 2 Diabetes and Major depressive disorder. Document review of the facility form dated 12/21/17, titled, Brief Interview for Mental Status (BIMS) revealed R101 was severely impaired and the Care Area Assessment (CAA) addressed impaired communication due to severely impaired cognition secondary to late onset Alzheimer's disease. The CAA form dated 7/6/17, included incontinence of bowel and bladder. Always incontinent of bladder requiring staff assistance of one every three hours and p.m. (whenever necessary) for incontinent cares.	2 920	Corrected	3/23/18

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2 920	Continued From page 14 The plan of care last revised 7/7/17, read, "I have functional bladder and bowel incontinence r/t severely impaired cognition with communication deficit and dependence on staff for incontinent cares 2' (secondary to) advanced late onset Alzheimer's disease. The intervention directed to check and change incontinent undergarment every 2-3 hours and prn (whenever necessary). The undated nursing assistant care sheet for toileting directed assist of 1 every two hours along with reposition every two hours. Pressure ulcer coccyx. Continuous observations were made of R101 on 2/12/18, from 12:00 p.m. until 3:28 p.m. and there was no offer of a check and change for incontinence care. At 12:00 p.m. R101 was seated at the dining room table waiting for lunch. At 1:00 p.m. nursing assistant (NA)-A sat with R101 to feed food and fluids. At 1:30 p.m. R101 was wheeled in the specialty chair to the day room for music therapy group activity. There were no offers for a check and change for incontinence care. At 2:00 p.m. R101 was wheeled in the specialty chair to the dining room for cookie baking group activity. There were no offers for a check and change for incontinence care. At 3:00 p.m. R101 continued to sit at the cookie baking activity. At 3:12 p.m. R101 was moved to the day room to watch the Olympics on television. At 3:16 p.m. NA-B wheeled R101 to the bedroom for cares. NA-B was in and out of the bedroom to obtain supplies and the mechanical stand for the transfer. Registered nurse (RN)-C came to the room to assist with the transfer. At 3:28 p.m. the mechanical lift raised R101 off buttocks into a standing position. Observations continued on 2/12/18, and at 3:37	2 920		

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2 920	Continued From page 15 p.m. NA-B and RN-C turned R101 to the side to remove the incontinence brief and visualize the buttocks and posterior thighs. There was a four by three circular dressing with clear tape borders at the coccyx and right buttocks which extended to the left buttock. Under the clear tape dressing extending to the left buttocks was a new red moist open area that measured 4.0 cm length by 1.4 cm width. RN-C removed the dressing from the coccyx which revealed a unstageable pressure ulcer approximately 4 cm by 2 cm. There were multiple red creases/craters and wrinkling of the skin to the buttocks and posterior thigh areas on R101. When interviewed on 2/12/18, at 4:00 p.m. nursing assistant (NA)-B verified not knowing what time the day shift completed a check and change for incontinence care. Furthermore, NA-B verified R101 should have been in bed by 2:30 p.m. but the time got away from NA-B. The Skin Integrity Management Policy dated revised 1/2017, indicated under the Care Plan, read, "The results of the comprehensive assessment are used to develop, review and revise resident's comprehensive plan of care. Based upon the findings of the clinical assessment in partnership with the resident and / or family input, a care plan will be developed or modified to reflect alterations in interventions and implementation of new interventions specific to the resident. The care planned interventions will get communicated to the appropriate staff via the nursing assistant assignment sheet or My Best Day and /or through report. Skin Protection addressed to assess and treat incontinence. When incontinence cannot be controlled, use appropriate-care with barrier cream to perineal area after each episode of incontinence.	2 920		

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2 920	Continued From page 16 During an interview with registered nurse (RN)-C on 2/14/18, at 8:30 a.m. verified inability to determine from the day shift what time R101 was toileted prior to surveyor observations on 2/12/17 from 12:00 p.m. through 3:30 p.m.. Furthermore RN-C verified the plan of care should have been updated to reflect R101 had a pressure ulcer on the coccyx and the toileting check and change should have reflected to be performed every two hours. 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.	2 920		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies.	21325		3/23/18

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21325	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain routine dental services for 1 of 2 residents (R157) identified with dental issues and receiving Medicaid services. Findings include: On 2/13/18, at 12:27 p.m. R157 was observed with multiple missing and a single front tooth on the upper gum line, and some missing teeth on the lower gum line. On 2/14/18, at 8:38 a.m. hospice aide (HA)-B stated R157 could be resistive to oral cares. HA-B showed the surveyor an undated computerized hospice care plan indicating R157 was resistive to oral cares and had poor teeth. An Oral/Dental Assessment dated 9/12/17, indicated that while R157 would not allow the dental hygienist (DH) to look in the mouth, R157 stated her teeth were bad and requested to see a dentist. The DH documented on the assessment that a routine dental referral was made, noting the need to see the dentist was not urgent. The care plan developed 3/13/17, directed staff to coordinate arrangements for dental care, transportation as needed/as ordered. A revision to the care plan dated 8/8/17, revealed R157 was at risk for oral/dental health problems related to refusal of cares at times. This revision also noted R157 had natural teeth and an upper partial was not worn. Review of the medical record revealed R157's request to see a dentist and the dental referral had not been followed upon. There was no	21325	Corrected	

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21325	Continued From page 18 documentation found indicating R157 had seen the dentist since being seen by the DH on 9/12/17. On 2/14/18, at 10:14 a.m. registered nurse (RN)-A provided a document titled, Oral Health Plan & Consent Form signed by R157 on 2/22/17. The consent form indicated R157 planned to refuse all oral health services "unless she has a need." RN-A did not know why R157's and the DH's dentist referral of 9/12/17, had not been followed up on. A copy of a facility policy regarding dental services was requested, but not received from the facility. SUGGESTED METHOD OF CORRECTION: The clinical manager could determine if the resident still desired to see a dentist, and if needed made a dental appointment. A review of the facility's policy regarding routine dental services could be review with nursing staff and the health unit coordinator to ensure all recommended dental appointments are followed up on. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		3/23/18

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21375	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the failed to ensure proper infection control practices were followed for 7 of 27 residents (R21, R41, R60, R102, R125, R156, R177) equipment reviewed for infection control. Findings include: On 2/14/18 at 2:29 p.m., nursing assistant (NA)-C was observed returning a Hoyer Lift to the storage area where another Hoyer Lift was already stored. NA-C had gloves on and proceeded to clean each lift with a disinfectant wipe. NA-C indicated each lift was cleaned between resident use. NA-C walked over to the medication cart, pointed to a container of blue top disinfectant wipes, and indicated he used those to clean the lifts. The blue top container safety data sheet dated 4/1/15, indicated product identifier: Sani-Hands Instant Hand Sanitizing Wipes with recommended use as an antiseptic. The purple top container safety data sheet dated 10/25/15, indicated product name: Super Sani-cloth Germicidal Wipe with recommended use as a disinfectant on hard, non-porous surfaces. On 2/15/18 at 8:08 a.m., the clinical administrator indicated when Hoer lifts are soiled staff should disinfect them with Sani-wipes from purple top containers. Mechanical Lift Transfer Policy dated 2/2016 indicated: "18. Lifts should be cleaned when soiled as needed and on a routine cleaning	21375	Corrected	

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21375	Continued From page 20 schedule." Infection Prevention and Control Manual General Policy dated 2017 indicated: "6. All items, other than disposables, are cleaned, disinfected, or sterilized, following federal, state and local guidelines and manufacturers recommendations. 7. Use of disinfectants, antiseptics, and germicides are by manufacturers' instructions and EPA or FDA label specifications to avoid harm to staff, residents and visitors and to ensure effectiveness." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures for infection control, and develop a system to ensure these policies and procedures are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance	21426		3/23/18

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21426	Continued From page 21 regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document complete results of the tuberculin skin skin (TST) administered to 3 of 6 residents (R6, R51, R160) reviewed for tuberculosis (TB) screening. Findings include: R6 was admitted to the facility on 10/26/17, per R6's admission Minimum Data Set (MDS). R6's immunization record revealed R6 was given the first step TST on 10/27/17, with negative results, but did not indicate the millimeter (mm) reading. R51 was admitted to the facility on 11/17/17, per R51's admission MDS. R51's immunization record revealed R51 was given the second step TST on 12/4/17, with negative results, but did not indicate the millimeter (mm) reading. R160 was admitted to the facility on 1/15/18, per R160's admission MDS. R160's immunization record revealed R160 was given the second step TST on 1/28/18, with negative results, but did not indicate the millimeter (mm) reading. On 2/5/18, at approximately 4:00 p.m., the clinical administrator stated she expected resident's TST	21426	Corrected	

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21426	Continued From page 22 results to have both 0 mm and negative readings. The facility's Tuberculosis Control Plan dated 6/2017 indicated: "A standard intradermal tuberculin skin test (TST) will be administered to all skilled facility residents within 72 hours of admission, unless there is written documentation of a negative TST within the last 3 months or if contraindicated in writing by a physician/nurse practitioner. A two-step TST procedure will be followed. If the initial TST is negative, the second step TB test should not be done until 14 days after the reading of the initial. The facility policy did not address the need for both 0 mm and negative readings. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures for tuberculosis screening, and develop a system to ensure these policies and procedures are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan	21530		3/23/18

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	00975	A. BUILDING: _____ B. WING _____	02/15/2018

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21530	Continued From page 23 system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to follow up on the consultant pharmacist's recommendation for monitoring psychotropic medications for 1 of 5 residents (R72) reviewed for psychotropic medications. Findings include:	21530	Corrected	

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21530	Continued From page 24 A review of R72's physician orders revealed R72 had an order for the antipsychotic medication Seroquel. Physician orders indicated Seroquel (Quetiapine Fumarate) 75 milligrams (mg) was to be administered one time a day for delirium. Review of R72's monthly pharmacist recommendations dated 9/22/17, included clarification of quetiapine indication and consideration of a quetiapine gdr (gradual dose reduction). Review of the Consultant Pharmacist Communication to Physician dated 9/22/17, indicated: "1. Her quetiapine order in PCC indicates that she is taking this for delirium. She has not had delirium symptoms/behavioral concerns noted in her recent charting. Is this still an appropriate indication?" R72's care plan included use of antipsychotic medication related to delirium and interventions included monitor/document for side effects and target behaviors. Review of R72's behavior monitoring for February did not indicate any monitoring was being done for delirium. On 2/15/18 at 10:42 a.m., registered nurse (RN)-E indicated per pharmacist recommendation on 9/29/17, Seroquel was decreased to 75 mg. RN-E indicated anytime there was a medication dosage decrease, we order daily monitoring and are looking for evidence of delusions. RN-E further indicated there were no specific notes documenting delusions and would update the provider. On 2/15/18, at 11:36 a.m. RN-E indicated she	21530		

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21530	Continued From page 25 had spoken with the consultant pharmacist who confirmed staff should be monitoring R72's behavior for delusions. On 2/15/18, at 4:21 p.m. the clinical administrator indicated behavior monitoring should be included with antipsychotic medications, side effect monitoring as well, and this should be care planned also. The Psychotropic and Unnecessary Medication Use Policy dated September 2017 indicated: "1. Specific target behaviors will be monitored for psychotropic medications." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures for psychotropic medication monitoring, and develop a system to ensure these policies and procedures are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans	21925		3/23/18

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21925	Continued From page 26 Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to notify a representative of the Office of the State Long-Term Care Ombudsman when the facility initiated a hospital transfer for 1 of 3 residents (R141) reviewed for hospitalizations. Findings include: A visit progress note, dated 12/12/17, revealed the nurse practitioner saw R141 in the facility on 12/12/17. The nurse practitioner noted concerns over the past several months with cognitive decline, and escalating behaviors. According to the note, R141 was combative and verbally abusive during the visit. The nurse practitioner described R141 as being "unable to be redirected and behavior is progressive." The plan written on page five of the note was to admit R141 to a specialized hospital unit for evaluation and treatment, because medications were ineffective. Review of written physician orders revealed the	21925	Corrected	

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nurse practitioner wrote an order on 12/12/17, to allow R141 to go to the specialized hospital unit to receive evaluation and treatment consultation for increasing behaviors that staff could not easily redirect.

A progress note, dated 12/13/17, revealed the facility discharged R141 to the hospital at 12:05 p.m. with family consent, related to the nurse practitioner's order.

A progress note, dated 1/2/18, revealed R141 readmitted to the facility around 10:30 a.m. from the hospital.

On 2/15/18, at 2:22 p.m. records were requested regarding whether staff sent notification of the facility initiated hospital transfer to a representative of the Office of the State Long-Term Care Ombudsman (OOLTC).

On 2/15/18, at 4:20 p.m. the administrator was unable to provide records of notification to the OOLTC. At 4:36 p.m. the administrator explained this was a planned facility initiated transfer to the hospital, because R141's behaviors had been escalating and ongoing, and the nurse practitioner witnessed the behaviors during a facility visit. The administrator confirmed that the facility had not sent notification of the hospital transfer to the OOLTC, because the corporate office had only been sending notification of unplanned, emergent transfers. The administrator was not aware that notification also needed to be sent to a representative from the OOLTC in the case of planned hospital transfers.

Review of the Discharge Policy and Procedure, approved October 2017, defined Facility Initiated Discharge as the following: "a transfer or

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21925	Continued From page 28 discharge which the resident representative did not initiate with a verbal or written request." The Discharge Policy and Procedure required the following for planned facility initiated discharges: "The facility will ensure that a notice is issued to the resident and the resident's representative within 30 days of the date of discharge. The facility must send a copy of this notice to the Office of the State Long Term Care Ombudsman at the same time as issuance to the resident." SUGGESTED METHOD OF CORRECTION: The Director of Social Work or designee could review facility policies and procedures for transfer and discharge notification, and develop a system to ensure the ombudsman is given notice when the facility initiates a resident transfer to the hospital. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		