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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FB66

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 **01/13/2014** (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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Susanne Reuss, Unit Supervor 01/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 4/10/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
02/07/2014 (L33)

DETERMINATION APPROVAL

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

CCN: 24-5424

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 11/21/13. On 01/13/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 11/21/13, effective 12/31/13. Refer to the CMS-2567B for both health and life safety code.

Effective 12/31/13, the facility is certified for 208 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Numer (CCN): 24-5424

March 14, 2014

Ms. Maria Garrity, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, Minnesota 55112

Dear Ms. Garrity:

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 December 31, 2013, the above facility is certified 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 14, 2014

Ms. Maria Garrity, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: Project Number S5424023

Dear Ms. Garrity:

On December 9, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 21, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 21, 2013, effective December 31, 2013 and therefore remedies outlined in our letter to you dated December 9, 2013, will not be imposed.

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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 651-201-3793 Fax: 651-201-3790

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245424	A. Building B. Wing	1/13/2014

Name of Facility	Street Address, City, State, Zip Code
PRESBYTERIAN HOMES OF ARDEN HILLS	3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/31/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/31/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/31/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	03/14/2014	16022	01/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/21/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FB66

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 **11/21/2013** (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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Mary Beth Lacina, HFE NE II 12/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/06/2014 (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**

CCN-24-5424

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7760

December 9, 2013

Ms. Maria Garrity, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, Minnesota 55112

RE: Project Number S5424023

Dear Ms.. Garrity:

On November 21, 2013, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<u>Informal Dispute Resolution</u> - 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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 31, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 February 21, 2014 (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 May 21, 2014 (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.

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

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 _____	11/21/2013

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified personal care experience for 3 of 5 residents (R29, R152, R191) observed dependent on others for activities of daily living. The facility also failed to provide a dignified dining experience for 2 of 2 residents (R251, R223) observed in the dining room. Findings include: R29 did not receive an ongoing explanation of cares throughout the care process while they were being performed by staff at 12:05 p.m. on 11/20/13.	F 241	F241 Education will be completed with staff on caring for residents with dignity including communication techniques for direct care. Education on lift procedures to include explanation of procedure. Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Education has also been initiated through Stand-Up (daily staff meetings). Upon notification of these instances by the survey team, the involved staff member(s) were re-educated regarding following the care plan and My Best Day.	12/31/13 12/23/13 SER

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

Paul Speman, RN | Clinical Administrator | 12/19/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	11/21/2013

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 241	Continued From page 1 During continued observation on 11/20/13, at 12:05 p.m. R29 had on the clothing protector from breakfast which was finished at 9:30 a.m. Nursing assistant (NA)-B and NA-C came into the room and without introductions NA-C said, "We are going to change you." NA-B started to put the mechanical lift sling behind R29's back without saying what was happening next. R29 began to scream out in protest. Licensed practical nurse came into the room and stated, "[R29} we have talked about this, we need to change your position so your skin does not get sore." R29 was crying but did allow the staff to transport her to bed for position change and incontinence care. The staff did not tell R29 where to put her arms during the transfer or when the mechanics of the mechanical lift were taking place in raising her out of the chair and again in lowering the lift onto the bed. R29 was incontinent of urine and loose bowel movement. NA-B informed R29 the spray being used for peri care was cold as it was sprayed on. The nursing assistants failed to inform the resident of each step in the process to alleviate anxiety with turning in the bed which way and why. The principal diagnosis from the plan of care lists unspecified peripheral vascular disease and further lists other specific muscle disorders, unspecified myoneural disorders (a chronic autoimmune neuromuscular disorder characterized by skeletal muscle weakness) and schizophrenia (mental disorder characterized by a breakdown of thought processes and by impaired emotional responses) unspecified condition. R29's Brief Interview for Mental Status (BIMS) dated 8/21/13,is a 15 out of a possible 15 which	F 241	Dignity audits while staff are providing direct care will be completed on 5% of residents weekly for four weeks and then 5% of residents for 2 months. Results of the audits will be reviewed with the facility QA committee. Action plans will be developed as needed. The Dining Room Protocol was reviewed and updated. All nursing staff will receive education regarding the updated via Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. For sustainability of Dining Room Protocol facility has integrated additional training for new hires implemented on 12/16/13 and ongoing. Random dining room audits will be completed on weekly basis for 4 weeks and then monthly	

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F 241	Continued From page 2 indicates Cognitive skills are independent and decisions consistent/reasonable. R29's plan of care dated 12/30/11, directed staff to "Educate me, my family or caregivers of a possible outcome (s) of not complying with treatment or care and document in my medical record. Encourage me to participate as much as possible during care activities. Give me clear explanation of all care activities prior to any as they occur during each contact. R152 was not informed of the importance for care during observation on 11/18/13 at 7:00 p.m. from nursing assistant (NA)-D. During continuous observation on 11/18/13, from 4:15 p.m. until 5:00 p.m. R152 was seated in a wheel chair with a pressure relieving cushion and was participating in an activity in the day room. During interview at 5:00 p.m. R152 stated, "Sometimes I sit a long time and my butt becomes tired." At 5:30 p.m. R152 was wheeled to the dining room for supper. At 6:45 p.m. R152 was wheeled to the day room to watch television. At 7:00 p.m. NA-D stated to R152, "You look tired, do you want to go to bed?" to which R152 stated, "No, I would like to watch television yet." There were no offers or attempts to toilet or reposition R152 or to explain the importance of a toileting/repositioning schedule. The principal diagnosis in the medical record lists paralysis agitans (a degenerative disorder of the central nervous system characterized by tremor and impaired motor coordination). Further diagnosis include muscular wasting and disuse	F 241	times 2 months to ensure compliance with updated Dining Room Protocol. All nursing staff will receive education regarding the communication while providing direct cares via Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Audits will be reviewed at Quality Assurance meeting for direction, change, or continuation based on compliance results. The administrator and/or designee are responsible for ongoing compliance. Date certain for ongoing compliance is 12/31/13.	

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F 241	Continued From page 3 atrophy and senile dementia with delirium. R152's BIMS was an 8 out of a possible 15 which indicates Cognitive skills are severely impaired and is rarely/never able to make decisions. R152's plan of care dated 12/27/11, read; I have impaired cognitive function due to dementia. The plan of care directed staff to; Communicate with me, family or caregivers regarding residents capabilities and needs as needed. Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. R191 was not informed in a dignified manner cares that were being performed. During observation on 11/20/13, at 10:05 a.m. NA-A and NA-B came to assist R191 to the bathroom (BR). NA-A and NA-B did not explain to R191 who they were or what they were going to do for R191. The NA's were attempting to position the mechanical lift and to apply the green lift sling without explaining the sling. R191 was saying, "I don't want to use the green one." (the sling was green and no simple explanation for it's use was offered.) The NA's were attempting to raise R191's arms to adjust for the sling and R191 stated, "It hurts, your hurting me, your hurting my legs.' NA-B was saying, "ok, ok, ok, hold on, hold on," NA's did not inform R191 where to position his arms for the transfer with the sling and the mechanical lift and did not inform him when they went to raise or lower the lift, which startled the resident. R191 continued to complain about the, "Greenery." The NA's did not explain the sling to R191. The NA's did not inform	F 241		

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F 241	Continued From page 4 the resident he was sitting on the toilet but did say, "Go now." NA-B did not inform R191 they were going to use a cold wet wipe to his scrotum and buttocks and R191 was startled by the process and attempted to move away from the wipe while suspended in the sling. R191 could not hear NA-B and had to say several times, "What?" When the NA's were lowering the mechanical lift for R191 to be put to bed, R191 was saying, "It hurts, it presses on my legs. what are you doing." NA-B was saying ,"ok, ok, ok," and R191 yelled, "It is not ok, it hurts me!" R191's BIMS dated 8/28/13, indicated a score of 4 out of a possible 15 indicating cognitive skills were severely impaired and was rarely/never able to make decisions. The care plan dated 12/29/11 read, "COMMUNICATION: Identify yourself at each interaction. Face me when speaking and make eye contact. Reduce any distractions. I understand consistent, simple, directive sentences." R191 has hearing difficulty and wears a hearing aide in the right ear. The principal diagnoses from R191's care plan listed unspecified late effect cerebral vascular disease (CVA) with other persistent mental disorder. R191's care plan dated 4/3/12, read, "I have alteration in skin integrity evidenced by vascular ulceration related to decreased circulation. Rt (right) inner heel and L (left) outer lower leg. I need assistance of one to turn/reposition in bed and wheelchair." When interviewed on 11/20/13, at 12:15 p.m. clinical coordinator LPN-B verified R29, R152 and R191 were to have cares explained by staff.	F 241		

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F 241	Continued From page 5 The facility undated training program titled; "Dementia Care Training" and "Enhancing Communication with the Resident" directed staff to Introduce yourself to the resident each time, Make good eye contact, be aware of body language, Be relaxed, patient and calm. Residents respond to your mood. Allow enough time for each interaction, Break down tasks into steps. Explain what you are doing, repeat instructions and questions at least twice exactly the same way. Don't be condescending. The facility failed to provide a dignified dining experience for R251. Review of R251's face sheet indicated a diagnosis of dementia. During breakfast dining room observation on 11/20/13, at 9:45 a.m. R251 was observed sitting at the dining room table with the breakfast meal in front of her. Nursing assistant (NA)-I placed a cart full of dirty dishes approximately two feet from R251. The bucket half full of water, milk and juice mixed together, discarded from other residents's breakfast, was placed on a chair approximately two feet away from R251. NA-I left the bucket of discarded fluids and cart of dirty dishes in the same location while serving another resident breakfast. R251 covered her nose with a tissue. While standing next to R251 an odor of discarded food and beverages was noticeable. During interview on 11/21/13, at 12:39 p.m. the community coordinator (CC)-C reported the expectation was the cart of dirty dishes and discard fluids be placed further away from dining residents.	F 241		

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F 241	Continued From page 6 Review of the Dining Room Protocol dated 4/29/10, directed staff, "10. Bus residents place settings as needed." No further directions were given related to placement of food waste from dining residents. The facility failed to provide a dignified dining experience for R223. Review of R223's face sheet indicated a diagnosis of dementia. During breakfast dining observation on 11/20/13, at 10:00 a.m. NA-I was observed clearing tables of food/beverage waste and dirty dishes. NA-I approached R223, seated at the dining room table, grabbed R223's glass full of water. NA-I holding onto R223's glasss of water with soiled gloved hands, asked if R223 still wanted the water. R223 stated did want the water. NA-I put the glass of water down and R223 drank it. During interview on 11/21/13, at 12:39 p.m. CC-C reported the expectation was for staff to wait until residents were finished eating before their dishes and food were cleared from the tables. The Dining Room Protocol dated 4/29/10, listed as procedure, "8. When residents have finished dining, offer wipes and offer to remove clothing protector and crumbs from their clothing. 9. Record food/fluid consumption. 10. Bus residents place setting as needed." The procedure directed staff to bus place settings only after the residents were finished dining.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246		

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F 246	Continued From page 7 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely serving of meals was provided for 1 of 5 residents (R21) observed during dining who was dependent on others for assistance with meals. Findings include: On 11/20/13, during breakfast meal observations on fourth floor, R21 was not served breakfast for approximately 65 minutes. R21's quarterly Minimum Data Set (MDS) assessment dated 09/18/13, identified R21 as needing extensive assistance of two staff with all activities of daily living, including eating. During the breakfast meal observations on fourth floor dining room on 11/20/13, at 8:00 a.m. R21 was wheeled by a staff member into the dining room for breakfast. At 8:25 a.m. a nurse administered medications to R21 and handed her a glass of water, R21 drank all of the water right away and the glass was empty. However, from 8:25 a.m. to 9:00 a.m. R21 kept placing the glass to her lips trying to drink more water from the empty glass. No one offered any other beverages to R21. There were two other residents who were eating their breakfast at the	F 246	F246 12/31/13 The process for identifying the resident needs for assistance at meal time was reviewed and updated for the 4th floor mealtimes. The Dining Room Protocol was reviewed and updated. All nursing staff will receive education regarding the updated Dining Room Protocol via Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Education has also been initiated through Stand-Up (daily staff meetings). Random dining room audits will be completed on weekly basis for 4 weeks and then monthly times 2 months to ensure compliance with updated Dining Room Protocol.	

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F 246	Continued From page 8 table, R21 would look at them and try to take a sip from the empty glass. At 9:00 a.m. a staff member asked nursing assistant (NA)-G to take R21 out of the dining room. NA-G wheeled R21 out of the dining room. When asked NA-G stated, "I don't know who put her in the dining room, there is no help to feed her right now in the dining room," and left R21 sitting in front of the fish tank next to south nursing station. At 9:05 a.m. NA-G wheeled R21 back to the dining room, obtained a breakfast tray, and started feeding R21. R21 sat and watched other residents eat/drink breakfast for approximately one hour before anyone served R21 her breakfast and assisted R21 to eat. During an interview with clinical coordinator, registered nurse (RN)-D and community coordinator (CC)-A on 11/20/13, at 9:40 a.m. they indicated fourth floor dining room was very busy during meal times and many residents who were cognitively impaired needed meal time assistance from staff. They indicated they asked for help from other floor staff during meal times to provide needed assistance to the complex residents. They said their expectation of staff in the dining room was to be observant and provide supervision to the residents. RN-D and CC-A stated they served breakfast as the residents came to the dining room since some residents preferred to sleep in late. They added, a resident should not wait in the dining room for an extended period of time unless they requested to sit and sip on a beverage. RN-D and CC-A confirmed R21 did not receive timely assistance with the breakfast meal on 11/20/13.	F 246	Audits will be reviewed at Quality Assurance meeting for direction, change, or continuation based on compliance results. The administrator and/or designee are responsible for ongoing compliance. Date certain for ongoing compliance is 12/31/13.	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 9 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not follow the care plan for 3 of 5 residents (R29, R152, R50) observed for repositioning and toileting/incontinence needs. Findings include: R29 did not receive assistance with repositioning every two hours or toileting (incontinence care) before and after meals according to the care plan. R29's care plan dated 8/20/13, directed staff, that R29 has potential for pressure ulcer development and to, "Reposition me: Tilt my w/c (wheelchair) back every two hours while I'm up in it. I need assistance of two to turn/reposition in bed and wheelchair every two hours." The care plan also directed staff to, "Check my incontinent undergarment and change upon rising, before meals and after meals, at HS (bedtime) and prn (whenever necessary)." The form titled "My Best Day" dated 11/21/13, directed staff to, "Assist of 2: MUST BE TOILETED EVERY 2 hrs. (hours) When in w/c (wheelchair) EVEN IF SHE REFUSES." Continuous observation of R29 on 11/18/13, from 4:15 p.m. until 7:30 p.m. (3 hours and 15 minutes) with no repositioning or incontinence	F 282	F282 12/31/13 Care plan policy was reviewed and remains accurate. Upon notification of these instances by the survey team, the involved staff member(s) were re-educated regarding following the care plan and My Best Day. Residents R 29 and R 152 were comprehensively assessed for skin risk. R 50 ~~and R191~~ were comprehensively reassessed for bowel and bladder. Education will be completed with staff on caring for residents in accordance with the care plan as communicated via My Best Day and/or Point of Care via Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Education has also been initiated through Stand-Up (daily staff meetings).	

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F 282	Continued From page 10 care. During continuous observation on 11/20/13, from 8:30 a.m. until 12:05 p.m. (3 hours and 35 minutes). R29 was up in a wheelchair without an offer of position change or check/change for incontinence. When interviewed on 11/20/13, at 12:15 p.m.clinical coordinator licensed practical nurse (LPN)-B verified R29 was to have a position change every two hours and incontinence care before and after meals. R152 did not receive assistance with repositioning or toileting (incontinence care every two hours and when necessary according to the care plan. R152's care plan dated 7/15/13, directed staff, "I have potential for pressure ulcer development due to immobility. Reposition every two hours while awake. I have bladder/bowel incontinence due to impaired mobility. Offer toilet upon arising and every two hours while awake." Continuous observation of R152 on 11/18/13, from 4:15 p.m. until 7:30 p.m. (3 hours and 15 minutes) there were no offers or attempts to reposition or toilet R152. During continuous observation of R152 on 11/20/13, from 7:00 a.m. until 9:45 a.m. (2 hours and 45 minutes), there were no offers or attempts to reposition or toilet R152. Interviews with nursing assistant (NA)-B and NA-E on 11/20/13, at 9:45 a.m. confirmed R152 was to have position changes and toileting every	F 282	A comprehensive care plan review was completed for R29, R152, R191, and R50 to ensure plan of care and resident needs are consistent. Random audits to address following the care plan will be completed on 5% of residents weekly for four weeks and then 5% of residents for 2 months. Audits will be reviewed at Quality Assurance meeting for direction, change, or continuation based on compliance results. The administrator and/or designee are responsible for ongoing compliance. Date certain for ongoing compliance is 12/31/13.	

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F 282	Continued From page 11 two hours. When interviewed on 11/20/13, at 12:15 p.m. clinical coordinator licensed practical nurse (LPN)-B verified R152 was to have a position change every two hours and toileting with incontinence care every two hours. The facility policy dated August 2010, and titled "Care Plan Policy and Procedure" read, "The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible." Step 10 of the policy read, "The care plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be written on the paper care plan in the resident's medical record. It is to be current at all times." R50 was incontinent of bowel and bladder, at risk for pressure ulcers, and the plan of care was not followed for repositioning and toileting needs on 11/20/13, from 7:15 a.m. until 9:50 a.m. during continuous observations. R50's incontinence care plan dated 7/15/13, directed staff R50 was incontinent of bowel and bladder. R50 used disposable incontinent briefs which were needed to be checked and changed, "before meal, with Hs (bedtime) care and prn (as needed)," during the night shift staff were directed to check and change R50's brief, "during 1st, 3rd and last rounds and PRN (as needed)," to keep R50 clean and dry. R50's skin integrity care plan dated 7/15/13, indicated R50 was at risk for alteration in skin integrity; needed assistance of two staff to turn and reposition every two hours and as needed. Due to limited physical mobility	F 282		

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F 282	Continued From page 12 R50 required assistance of two staff with transfers and utilized a wheelchair propelled by staff for mobility. On 11/20/13, from 7:15 a.m. to 8:00 a.m. R50 was sitting in a wheelchair on top of a pressure relieving cushion covered with a large Hoyer lift sling. At 8:00 a.m. a staff member wheeled R50 to the dining room for breakfast and was provided beverages and a banana. R50 sipped on orange juice, water and took bits of the banana. At 8:48 a.m. the breakfast tray was served to R50 and after set-up R50 began eating. At 9:08 a.m. R50 was taken to her room where R50 started watching television, meanwhile the door remained opened. At 9:38 a.m. nursing assistant (NA)-K and (NA)-L transfered R50 using a Hoyer lift (mechanical lift) from the wheelchair onto the bed. R50's incontinence brief was not checked to see if it needed to be changed by either nursing assistant before they left the room. At 9:50 a.m. NA-K returned to R50's room to check/change R50's incontinence brief. R50's incontinence brief was saturated with urine and stool. During an interview with nursing assistant (NA)-K on 11/20/13, at 9:44 a.m. NA-K confirmed R50 was last checked/changed and repositioned sometime just before 7:00 a.m. and was on an every two hour schedule. NA-K added, "I did not check pad because people were in there, but I will go there now, let me check on this other resident first." At 9:50 a.m. NA-K check and change R50's pad. During an interview with registered nurse (RN)-E on 11/21/13, at 8:55 a.m. RN-E stated the	F 282		

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	245424	A. BUILDING _____ B. WING _____	11/21/2013

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F 282	Continued From page 13 expectation of nursing aide staff was to provide the cares as listed on the care plan and in "My Best Day" nursing aide assignment sheets, which were posted in each room and also kept at the nursing desk.	F 282		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide repositioning every two hours for 4 of 5 residents (R29, R152, R191, R50) observed who were at risk for skin breakdown. Findings include: R29 was at risk for skin breakdown and did not receive assistance to reposition every two hours on 11/18/13, from 4:15 p.m. until 7:30 p.m. (3 hours and 15 minutes) and on 11/20/13, from 8:30 a.m. until 12:05 p.m. (3 hours and 35 minutes). During continuous observation on 11/18/13, from 4:15 p.m. until 7:30 p.m. R29 was seated in a	F 314	F314 12/31/13 The Policy and Procedure for skin risk was reviewed and remains accurate. Upon notification of these instances by the survey team, the involved staff member(s) were re-educated regarding following the care plan and My Best Day. A Comprehensive Skin Assessment was completed for R29, R152, R191, and R50 to ensure plan of care and resident needs are consistent.	

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F 314	Continued From page 14 wheel chair with a pressure relieving cushion in place. At 4:15 p.m. R29 was in the bedroom watching television and eating a cookie. At 5:15 p.m. R29 was taken to the dining room for supper and required feeding assistance. At 6:45 p.m. R29 was wheeled back to the bedroom and set in front of the television. At 7:30 p.m. R29 remained seated in the wheelchair and there were no offers or attempts to change R29's position. During continuous observation on 11/20/13, R29 was up in the wheelchair at 8:30 a.m. and brought to the dining room at 8:35 a.m. At 9:03 breakfast was served and R29 received assistance with eating. At 9:30 a.m. R29 was returned to the bedroom and resumed watching television sitting in the wheelchair. During all observations R29's door remained open and R29 could watch out into the hallway as well as watch television. At 12:05 p.m. nursing assistant (NA)-B and NA-C came with the mechanical lift to change R29's position. Upon removal of the brief, R29's skin and thighs had numerous deep red craters and crevices from the wrinkling of the brief. The areas were blancheable at the time. The quarterly Minimum Data Set (QMDS) dated 8/21/13, indicated R29 required total assistance of two staff for bed mobility, transfers, was at risk for developing pressure ulcers, and was on a turning/repositioning program. R29's principal diagnosis as indicated on the care plan dated 8/20/13, listed unspecified peripheral vascular disease. R29's careplan further listed other specific muscle disorders, unspecified myoneural disorders (a chronic autoimmune neuromuscular disorder characterized by skeletal muscle weakness) and schizophrenia (mental	F 314	Education will be completed with staff on caring for residents in accordance with the care plan as communicated via My Best Day and/or Point of Care via Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Education has also been initiated through Stand-Up (daily staff meetings). Random audits to address following the care plan will be completed on 5% of residents weekly for four weeks and then 5% of residents for 2 months. Audits will be reviewed at Quality Assurance meeting for direction, change, or continuation based on compliance results. The administrator and/or designee are responsible for ongoing compliance. Date certain for ongoing compliance is 12/31/13.	

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F 314	Continued From page 15 disorder characterized by a breakdown of thought processes and by impaired emotional responses) unspecified condition. R29's plan of care dated 8/20/13, read, "I have potential for pressure ulcer development r/t (related to) Hx (history) of ulcers, Immobility" and directed staff to, "Reposition me: Tilt my w/c (wheelchair) back every two hours while I'm up in it. I need assistance of two to turn/reposition in bed and wheelchair every two hours. If I refuse treatment confer with me, IDT (interdisciplinary team) and family to determine why and try alternative methods to gain compliance. Resident is resistive to repositioning. Risk & benefits have been explained to family & resident. Staff to attempt reapproaching." R29's Brief Interview for Mental Status (BIMS) dated 8/21/13, indicated a score of 15 out of a possible 15 (cognitive skills are independent and decisions consistent/reasonable). The form titled Braden Scale for Predicting Pressure Sore Risk and dated 2/19/13, indicated moderate risk currently for developing pressure ulcers. During an interview on 11/20/13, at 12:15 p.m. NA-B confirmed there should have been a position change every two hours for R29. R152 was at risk for skin breakdown and did not receive assistance to reposition every two hours on 11/18/13, from 4:15 p.m. until 7:30 p.m. (3 hours and 15 minutes); and on 11/20/13, from 7:00 a.m. until 9:45 a.m. (2 hours and 45 minutes). During continuous observation on 11/18/13, from 4:15 p.m. until 5:00 p.m. R152 was seated in a wheelchair with a pressure relieving cushion and	F 314		

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F 314	Continued From page 16 was participating in an activity in the day room. During interview at 5:00 p.m. R152 stated, "Sometimes I sit a long time and my butt becomes tired." At 5:30 p.m. R152 was wheeled to the dining room for supper. At 6:45 p.m. R152 was wheeled to the day room to watch television. At 7:00 p.m. NA-D stated to R152, "You look tired, do you want to ge to bed?" to which R152 stated, "No, I would like to watch television yet." There were no offers or attempts to reposition R152 or to explain the importance of a position change. During continuous observation of R152 on 11/20/13, from 7:00 a.m.when transported to the wheelchair via mechanical stand and remained in the bedroom watching television sitting in the wheelchair. At 8:20 a.m. R152 was calling out, "Hello, Hello, Hello here I am." At 8:25 a.m. R152 was wheeled to the dining room for breakfast. At 9:35 a.m., after sitting for 2 hours and 45 minutes, R152 was taken to the bedroom and at 9:45 a.m. NA-B and NA-E stood R152 in the mechanical stand to relieve pressure from buttocks. The QMDS dated 8/7/13, indicated R152 required extensive assistance of two staff with bed mobility, total assistance of two staff with transfers, was at risk for developing pressure ulcers and was on a turning/repositioning program. R152's principal diagnosis in the medical record listed paralysis agitans (a degenerative disorder of the central nervous system characterized by tremor and impaired motor coordination). Other diagnoses included muscular wasting, disuse atrophy, and senile dementia with delirium.	F 314		

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F 314	Continued From page 17 R152's BIMS score was 8 out of a possible 15 indicating cognitive skills were severely impaired and was rarely/never able to make decisions. The form titled "Braden Scale for Predicting Pressure Sore Risk" and dated 10/26/13, indicated mild risk. R152's care plan dated 7/15/13, read; "I have potential for pressure ulcer development due to immobility. Reposition every two hours while awake." Interviews with NA-B and NA-E on 11/20/13, at 9:45 a.m. confirmed R152 was to have position changes every two hours. The facility policy dated December 2010, titled "Skin Risk Policy" under Education read, "Provide education to resident and responsible party/families. If a resident refuses treatment or preventative interventions the risks and benefits will be discussed and documented in the resident's medical record. The physician or designee along with the responsible party will be updated on resident's refusal." R191 did not receive assistance with repositioning every two hours according to the facility document titled "My Best Day" which staff used as a "Quick Guide to ADL's (activities of daily living)" and directed staff to reposition R191 every two hours. During observation on 11/18/13, at 5:00 p.m. R191 complained of right leg pain. NA-D assigned to care for R191 was interviewed about when R191 last had a position change. NA-D	F 314		

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F 314	Continued From page 18 stated, "Maybe at two." R191 was not repositioned for approximately three hours. NA-D confirmed R191 was to have a position change every two hours. The quarterly Minimum Data Set (QMDS) dated 8/28/13, indicated R191 required extensive assistance of two staff for bed mobility,total assistance of two staff for transfers, was at risk for developing pressure ulcers, and was on a turning/repositioning program. R191's BIMS dated 8/28/13, indicated a score of 4 out of a possible 15 indicating cognitive skills were severely impaired and was rarely/never able to make decisions. The form titled "Braden Scale for Predicting Pressure Sore Risk" and dated 5/14/13, indicated moderate risk for development of pressure ulcers. The principal diagnoses from R191's care plan listed unspecified late effect cerebral vascular disease (CVA) with other persistent mental disorder. R191's care plan dated 4/3/12, read, "I have alteration in skin integrity evidenced by vascular ulceration related to decreased circulation. Rt (right) inner heel and L (left) outer lower leg. I need assistance of one to turn/reposition in bed and wheelchair." When interviewed on 11/20/13, at 12:15 p.m. clinical coordinator LPN-B verified R29, R152 and R191 were to have a position changes every two hours. R50 was at risk for skin breakdown and was not repositioned every two hours on 11/20/13, from 7:15 a.m. until 9:38 a.m. (2 hours and 23 minutes).	F 314		

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F 314	Continued From page 19 During continuous observation on 11/20/13, from 7:15 a.m. until 9:38 a.m. R50 was up in the wheelchair with a pressure relieving cushion and a large green lift sling in place. At 8:00 a.m. R50 was brought to the dining room for breakfast and required meal set up. Between 8:00 a.m. and 8:48 a.m. was either drinking water/orange juice or eating a banana. At 8:48 a.m. breakfast was served and R50 began eating after setup. At 9:08 a.m. R50 was returned to her room and resumed watching television sitting in the wheelchair. At 9:38 a.m. nursing assistant (NA)-K and NA-L transferred R50 from wheelchair via a mechanical onto the bed. At 9:50 a.m. when NA-K returned to R50's room to check/change R50's incontinenc brief, R50's buttocks were observed to have creases and reddened areas. The quarterly Minimum Data Set (QMDS) dated 9/25/13, indicated R50 required total assistance of two staff for bed mobility, transfers, and was on a turning/repositioning program. Also it indicated R50's Brief Interview for Mental Status (BIMS) score was 5 out of a possible 15 indicative of cognitive skills were severely impaired and was rarely/never able to make decisions. The QMDS indicated R50's diagnoses included cerebrovascular accident (stroke), depression, diabetes mellitus and obesity. R50's Care Area Assessment (CAA) dated 7/8/13, revealed, "Resident requires assistance of 1-2 staff with transfers, repositioning, and completing her ADLs related to impaired vision and impaired mobility r/t (related to) CVA (cerebrovascular accident) and obesity. " In addition, staff needed to provide repositioning every two hours and as needed, and lay down	F 314		

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F 314	Continued From page 20 R50 between meals to promote skin integrity. The nurse aide assignment sheet called "My Best Days," and dated 10/7/13, was posted inside the closet door and directed staff to reposition R50 every two hours and as needed with assist of two staff to maintain R50's skin integrity. R50's skin integrity plan of care dated 7/15/13, addressed R50 as being at risk for alteration in skin integrity; needed 2 staff members assistance to turn and reposition every 2 hours and as needed. Due to limited physical mobility R50 required 2 staff members assistance with transfers and utilized a wheelchair propelled by staff for mobility. During an interview with nursing assistant (NA)-K on 11/20/13, at 9:44 a.m. NA-K confirmed R50 was last repositioned sometime just before 7:00 a.m. and was on an every two hour schedule. During an interview with registered nurse (RN)-E on 11/21/13, at 8:55 a.m. RN-E stated the expectation of nursing aide staff was to provide the cares as listed on the plan of care and in "My Best Day" nursing aide assignment sheets and were posted in each room and also kept at the nursing desk. The facility policy titled "Care Plan Policy and Procedure" dated 8/10, read, "The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible." Step 10 of the policy read, "The care plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be written on the paper care plan in the resident's medical	F 314		

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F 314	Continued From page 21 record. It is to be current art all times." The facility policy dated December 2010, titled "Skin Risk Policy" under Activity, Mobility, and Positioning indicated, "2. Establish and record an individualized turning and repositioning schedule if the resident is immobile." In addition, under Education read, "Provide education to resident and responsible party/ families. If a resident refuses treatment or preventative interventions the risks and benefits will be discussed and documented in the resident's medical record. The physician or designee along with the responsible party will be updated on resident's refusal."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to check/change or offer toileting every two hours for 3 of 5 residents (R29, R152, R50) observed who were dependent on others and incontinent of bladder. Findings include:	F 315	F315 12/31/13 The Bowl and Bladder Assessment Policy was reviewed and remains accurate. Upon notification of these instances by the survey team, the involved staff member(s) were re-educated regarding following the care plan and My Best Day. A Bowel and Bladder assessment was completed for R29, R152, and R50 to ensure plan of care and resident needs are consistent.	

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F 315	Continued From page 22 R29 was incontinent of bladder and did not receive assistance with incontinence care every two hours or before meals on 11/18/13, from 4:15 p.m. until 7:30 p.m. (3 hours and 15 minutes); and on 11/20/13, from 8:30 a.m. until 12:05 p.m. (3 hours and 35 minutes). During continuous observation on 11/18/13, from 4:15 p.m. until 7:30 p.m. R29 was seated in a wheelchair with a pressure relieving cushion in place. At 4:15 p.m. R29 was in the bedroom watching television and eating a cookie. At 5:15 p.m. R29 was taken to the dining room for supper and required feeding assistance. At 6:45 p.m. R29 was wheeled back to the bedroom and set in front of the television. At 7:30 p.m. R29 remained seated in the wheelchair and there were no offers or attempts to check/change R29's incontinence brief. During continuous observation on 11/20/13, R29 was up in the wheelchair at 8:30 a.m. and brought to the dining room at 8:35 a.m. At 9:03 breakfast was served and R29 received assistance with eating. At 9:30 a.m. R29 was returned to the bedroom and resumed watching television sitting in the wheelchair. During all observations R29's door remained open and R29 could watch out into the hallway as well as watch television. At 12:05 p.m. nursing assistant (NA)-B and NA-C came with the mechanical lift to check/change R29's incontinence brief. R29's incontinence brief was saturated with urine and loose bowel movement. The quarterly Minimum Data Set (QMDS) dated 8/21/13, indicated R29 required total assistance of two staff with transfers, extensive assistance of two staff with toileting, and was always	F 315	Education will be completed with staff on caring for residents in accordance with the care plan as communicated via My Best Day and/or Point of Care via Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Education has also been initiated through Stand-Up (daily staff meetings). Random audits to address following the care plan related to toileting will be completed on 5% of residents weekly for four weeks and then 5% of residents for 2 months. Audits will be reviewed at Quality Assurance meeting for direction, change, or continuation based on compliance results. The administrator and/or designee are responsible for ongoing compliance. Date certain for ongoing compliance is 12/31/13.	

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F 315	Continued From page 23 incontinent of bladder. R29's Brief Interview for Mental Status (BIMS) dated 8/21/13, indicated a score of 15 out of a possible15 which indicated cognitive skills are independent and decisions consistent/reasonable. R29's principal diagnosis from the care plan dated 8/20/13, listed unspecified peripheral vascular disease. The care plan further listed other specific muscle disorders, unspecified myoneural disorders (a chronic autoimmune neuromuscular disorder characterized by skeletal muscle weakness) and schizophrenia (mental disorder characterized by a breakdown of thought processes and by impaired emotional responses) unspecified condition. R29's care plan dated 8/20/13, read, "I have FUNCTIONAL bladder/bowel incontinence r/t (related to) Neurogenic disorder. Check my incontinent undergarment and change upon rising, before meals and after meals, at HS (bedtime) and prn (whenever necessary)." The form titled "My Best Day" dated 11/21/13, directed staff to, "Assist of 2: MUST BE TOILETED EVERY 2 hrs. (hours) When in w/c (wheelchair) EVEN IF SHE REFUSES." During an interview on 11/20/13, at 12:15 p.m. with NA-B and clinical coordinator licensed practical nurse (LPN)-B confirmed there should have been a check/change of the incontinence brief every two hours for R29. R152 was at risk for incontinence and did not receive assistance with toileting every two hours on 11/18/13, from 4:15 p.m. until 7:30 p.m. (3	F 315		

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(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 315	Continued From page 24 hours and 15 minutes); and on 11/20/13 from 7:00 a.m. until 9:45 a.m. (2 hours and 45 minutes). During continuous observation on 11/18/13, from 4:15 p.m. until 5:00 p.m. R152 was seated in a wheel chair with a pressure relieving cushion and was participating in an activity in the day room. During interview at 5:00 p.m. R152 stated, "Sometimes I sit a long time and my butt becomes tired." At 5:30 p.m. R152 was wheeled to the dining room for supper. At 6:45 p.m. R152 was wheeled to the day room to watch television. At 7:00 p.m. NA-D stated to R152, "You look tired, do you want to ge to bed?" to which R152 stated, "No, I would like to watch television yet." There were no offers or attempts to toilet R152 or to explain the importance of a toileting schedule. During continuous observation of R152 on 11/20/13, from 7:00 a.m.when transported to the wheelchair via mechanical stand R152 remained in the bedroom watching television. At 8:20 a.m. R152 was calling out, "Hello, Hello, Hello here I am." At 8:25 R152 was wheeled to the dining room for breakfast. At 9:35 a.m. was taken to bedroom and at 9:45 a.m. NA-B and NA-E stood R152 in the mechanical stand to relieve pressure from buttocks. (2 hours and 45 minutes). NA-B and NA-E verified they did not check R152 for incontinence and did not offer toileting to R152 at the time. The quarterly Minimum Data Set (QMDS) dated 8/7/13, indicated R152 required extensive assistance of two staff with transfers, toileting, and was always incontinent of bladder. R152's BIMS indicated a score of 8 out of a	F 315		

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	245424	A. BUILDING _____ B. WING _____	11/21/2013

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F 315	Continued From page 25 possible 15 which indicated cognitive skills were severely impaired and was rarely/never able to make decisions. R152's principal diagnosis in the medical record listed paralysis agitans (a degenerative disorder of the central nervous system characterized by tremor and impaired motor coordination). Further diagnoses included muscular wasting, disuse atrophy and senile dementia with delirium. R152's care plan dated 7/15/13, read; "I have FUNCTIONAL bladder/bowel incontinence r/t (related to) Impaired mobility, History of UTI (urinary tract infection) Decreased physical mobility. Offer toilet upon arising and every two hours while awake." The facility policy dated 7/10, and titled "Bowel and Bladder Assessment Policy" indicated an individualized toileting plan would be developed for each resident and that the plan of care would be developed for interventions for elimination at the highest level of bowel and bladder function as possible. The policy directed, "The NAR (nursing assistant registered) assignment sheet or "My Best Day" will be updated to match the toileting/elimination plan as per the resident care plan." Interviews with NA-B and NA-E on 11/20/13, at 9:45 a.m. confirmed R152 was to have toileting every two hours and both verified toileting did not occur every two hours. When interviewed on 11/20/13, at 12:15 p.m. clinical coordinator LPN-B verified R152 was to have a toileting schedule of every two hours.	F 315		

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F 315	Continued From page 26 Resident (R50) was incontinent of bladder and did not receive assistance with incontinence care every two hours on 11/20/13, from 7:15 a.m. until 9:50 a.m. (2 hours and 35 minutes) during continuous observations. On 11/20/13, from 7:15 a.m. to 8:00 a.m. R50 was sitting in a wheelchair on top of a pressure relieving cushion covered with a large Hoyer lift sling. At 8:00 a.m. a staff member wheeled R50 to the dining room for breakfast and was provided beverages and a banana. R50 sipped on orange juice, water and took bits of banana. At 8:48 a.m. the breakfast tray was served to R50 and after set-up R50 began eating. At 9:08 a.m. R50 was taken to room and started watching television, meanwhile the room door remained opened. At 9:38 a.m. nursing assistant (NA)-K and (NA)-L transfered R50 using a Hoyer lift (mechanical lift) from the wheelchair onto the bed. R50's incontinent brief was not checked by either nursing assistant to see if it needed to be changed before they left the room. At 9:50 a.m. NA-K returned to R50's room to check/change R50's incontinenc brief. R50's incontinence brief was saturated with urine and stool. The quarterly Minimum Data Set (QMDS) dated 9/25/13, indicated R50 required total assistance of two staff for bed mobility, transfers, and toileting. The QMDS indicated R50 was always incontinent of bladder. R50's Brief Interview for Mental Status (BIMS) score dated 9/25/13, was 5 out of a possible 15 indicative of cognitive skills were severely impaired and was rarely/never able to make decisions. The QMDS indicated R50's diagnoses included cerebrovascular accident (stroke), depression, diabetes mellitus and	F 315		

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F 315	Continued From page 27 obesity. The nurse aide assignment sheet dated 10/7/13, called "My Best Days," was posted inside the closet door in the room and directed staff to reposition and toilet R50 every two hours and as needed while awake. In addition, the nurse aide assignment sheet indicated to check and change R50's incontinent brief before meals, with evening cares, and 1st and 3rd rounds during the night shift to maintain R50's skin clean and dry. The bowel and bladder evaluation documentation dated 07/2/13, indicated R50 was unable to make needs for toileting and repositioning known and staff needed to anticipate and follow the care plan to check/change R50 every two hours and as needed. The Care Area Assessment (CAA) dated 7/8/13, revealed R50 wore an extra extra large brief and staff needed to check/change the brief every two hours and as needed. In addition, staff needed to provide perineum cares after each incontinent episode and apply protective cream to promote skin integrity. R50's incontinence plan of care dated 7/15/13, revealed R50 was incontinent of bowel and bladder, and used incontinent briefs. The care plan directed staff to check/change R50's briefs, "before meal, with Hs (bedtime) care and prn (as needed)," during the night shift staff were directed to check and change R50's brief, "during 1st, 3rd and last rounds and PRN (as needed)," to keep R50 clean and dry. During an interview with nursing assistant (NA)-K on 11/20/13, at 9:44 a.m. NA-K confirmed R50	F 315		

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F 315	Continued From page 28 was last checked/changed and repositioned sometime just before 7:00 a.m. and was on an every two hour schedule. NA-K added, "I did not check pad because people were in there, but I will go there now, let me check on this other resident first." At 9:50 a.m. NA-K check/changed R50's pad which was saturated with urine and feces. During an interview with registered nurse (RN)-E on 11/21/13, at 8:55 a.m. RN-E stated the expectation of nursing aide staff was to provide the cares as listed on the care plan and in "My Best Day" nursing aide assignment sheets, which were posted in each room and also kept at the nursing desk. The facility document titled "Care Plan Policy and Procedure" dated 8/10, read, "The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible." Step 10 of the policy read, "The care plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be written on the paper care plan in the resident's medical record. It is to be current art all times." The facility policy dated 7/10, and titled "Bowel and Bladder Assessment Policy" indicated an individualized toileting plan would be developed for each resident and the care plan would be developed for interventions for elimination at the highest level of bowel and bladder function as possible. The policy directed, "The NAR (nursing assistant registered) assignment sheet or "My Best Day" will be updated to match the toileting/elimination plan as per the resident care plan."	F 315		

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F 356	Continued From page 29	F 356		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift	F 356	F356 12/31/13 Hours for nursing staff will be posted according to guidelines set forward by Health and Human Services and MDH. The proper requirements were added to the Nursing Hours Posting to include the actual shift hours worked by licensed and unlicensed staff. The policy for direct care staff hours posted was reviewed and is current. Nursing staff and staffing personnel responsible for implementation of Nursing Hours Posting were oriented on use of new tool. This posting will be reviewed weekly for 30 days and monthly for 2 months accuracy. The administrator and/or designee are responsible for ongoing compliance. Date certain for ongoing compliance is 12/31/13.	

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F 356	Continued From page 30 on 11/18/13, 11/19/13, 11/20/13 and 11/21/13. This had the potential to affect visitors and all 203 residents residing in the facility. Findings include: During the initial tour on 11/18/13, at 11:45 a.m. the facilty nursing staff posting on a wall was observed in the main lobby area. The posted nursing staff information lacked the actual shifts worked by the licensed and unlicensed staff who provided direct cares to the residents. During the random observations of the nursing staff posting forms posted in the lobby wall on 11/19/13, 11/20/13, and 11/21/13, it was noted the daily shift hours for the licensed and unlicensed staff was lacking to reflect how many hours each shift the staff had worked on the units. On 11/21/13, at 3:00 p.m. these forms were reviewed with the director of nursing (DON) who indicated it was new to him that exact shift hours for licensed and unclicensed staff had to be posted, however, DON stated they will add the actual shift hours on their forms from now on. During the interview with the administrator on 11/21/13, at 4:07 p.m. the administrator confirmed the staff hour posting form was incorrect lacking actual shift hours worked by licensed and unlicensed staff. The administrator added, "Will fix it and put in place."	F 356		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 37	F371 The Infection Control Policy/Procedure Hand Hygiene was reviewed and remains accurate.	12/31/13

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F 371	Continued From page 31 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff utilized appropriate hand hygiene during meal service, including glove change and/or hand washing and failed to ensure ready to eat foods were handled in a sanitary manner. The facility also failed to ensure hand hygiene was implemented for 1 of 1 resident (R223) observed who was still eating/drinking. This had the potential to affect 21 of 21 residents who received and were served food items in second floor South dining room, of the 203 residents who resided in the facility. Findings include: During the afternoon meal in second floor South dining room on 11/18/13, 12:45 p.m. the following was observed. The food server (FS)-B with gloved hands put food items on resident plates. FS-B was observed touching a drawer handle, the bottom portion of the Dutch door, took a paper towel and wiped the counter/sink next to the food cart. FS-B then grabbed plastic bags, and touched the outside of box of gloves. In addition, FS-B proceeded to check food temperatures without sanitizing the thermometer or wiping the thermometer in between food temperature checks, and then took a pen to log the food temperatures. While wearing the same	F 37	Upon notification of these instances by the survey team, the involved staff member(s) were re-educated regarding this policy. The Dining Room Protocol was reviewed and updated. All nursing staff will receive education regarding the updated Dining Room Protocol via Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Education has also been initiated through Stand-Up (daily staff meetings). Additionally Food Service employees will receive education regarding updated Dining Room Protocol along with Glove and Hand Washing for Food Service beginning on 12/17/13 and ongoing. Random dining room and kitchenette audits will be completed on weekly basis for 4 weeks and then monthly times 2 months to ensure compliance with updated Dining Room Protocol. Audits will be reviewed at Quality Assurance meeting for direction, change, or continuation based on compliance results.	

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F 371	Continued From page 32 gloves FS-B touched the food cart next to the sink area. FS-B did not wash hands, or change gloves during the entire meal service. During evening dining observation on 11/18/13, at approximately 5:45 p.m. nursing assistant (NA)-J was observed wearing gloves when assisting dependent residents with their meals in the dining room. NA-J touched her uniform, a spoon, and soup bowl while serving soup. NA-J opened a package of crackers and touched the crackers with the same gloved hands and then touched the food cart. NA-J wore the same gloves until 6:05 p.m. At 6:14 p.m. FS-C was observed changing gloves without washing hands. FS-C served food, touched a serving scoop, the food cart, a drawer handle and the bottom portion of the Dutch door. During an interview on 11/18/13, at 6:23 p.m. FS-C verified wore the gloves during the meal service and changed gloves at some point but did not wash hands or sanitized them in between. An interview conducted on 11/18/13, at 6:43 p.m. with NA-J and when questioned about hand washing between glove changes, NA-J stated, we don't normally wash hands between glove changes. During an interview with the director of nursing and administrator on 11/21/13, at 8:30 a.m. they stated their expectation was for staff to wash their hands between gloves change or use hand sanitizer in between, depending on what cares the staff was providing. The facility failed to ensure hand hygiene was implemented by nursing assistants on 11/20/13,	F 371	The administrator and/or designee are responsible for ongoing compliance. Date certain for ongoing compliance is 12/31/13.	

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F 371	Continued From page 33 during the breakfast service in the second floor South dining room for R223. During breakfast dining observation on 11/20/13, at 10:00 a.m. the nursing assistant (NA)-I was observed clearing tables of food/beverage waste and dirty dishes. Without washing hands or changing gloves, NA-I approached R223, seated at the dining room table, grabbed R223's glass full of water. NA-I while holding onto R223's glass of water with soiled gloved hands, asked if R223 still wanted the water. R223 stated she did want the water. NA-I put the glass of water down and R223 drank it. During interview on 11/21/13, at 12:39 p.m. the community coordinator (CC)-C reported NA-I touching R223's water glass with soiled gloved hands would not meet the dining room service expectations. The Infection Control Glove Technique (Non-Sterile) procedure dated 2010, directed staff, "Wear clean, non-sterile gloves when touching blood, body fluids, secretions, excretions and contaminated items." "Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other resident or environments."	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	F441 12/31/13 The Perineal Care Policy and Infection Control: Glove Technique was reviewed and remains accurate.	

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F 441	Continued From page 34 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff followed proper hand washing to prevent the potential	F 441	Upon notification of an instance by the survey team, the involved staff member(s) were re-educated regarding changing of gloves and hand washing. Education will be completed with staff on reinforcing proper hand washing and perineal cares via Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or by individual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Education has also been initiated through Stand-Up (daily staff meetings) and is completed annually in competency class. Random audits to address following hand washing and gloves related to peri cares will be completed on 5% of residents weekly for four weeks and then 5% of residents for 2 months. Dining room will be completed on weekly basis for 4 weeks and then monthly times 2 months to ensure compliance in following the plan of care. Audits will be reviewed at Quality Assurance meeting for direction, change, or continuation based on compliance results.	

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F 441	Continued From page 35 spread of infections for 1 of 2 residents (R50) reviewed for urinary incontinence. Padded grab bars in 2 of 2 residents (R11, R82) rooms did not have a cleanable surface. Findings include: Handwashing did not occur between glove changes by the nursing assistant when pericare was provided for R50 on 11/20/13, at 9:50 a.m. after being incontinent of bowel and bladder. On 11/20/13, at 9:50 a.m. nursing assistant (NA)-K was observed going into R50's room. NA-K donned a pair of gloves prior to providing pericare. R50's incontinence brief was saturated with urine and stool. NA-K grabbed a disposablie wipe and provided pericare for R50. During the entire process, NA-K was observed changing gloves twice but never washed hands. NA-K also applied peri-cream to R50's bottom. At 9:58 a.m. NA-K took the soiled incontinent brief out of R50's room went to the soiled ultility room, touched the door knob, and disposed of soiled incontinence brief and then washed both hands. The quarterly Minimum Data Set (QMDS) dated 9/25/13, indicated R50 required total assistance of two staff for toileting. The Care Area Assessment (CAA) dated 7/8/13, revealed, "Resident requires assistance of 1-2 staff with transfers, repositioning, and completing ADLs related to impaired vision and impaired mobility r/t (related to) CVA (cerebrovascular accident) and obesity." During an interview conducted on 11/20/13, at 10:02 a.m. NA-Kverified had never washed both	F 441	The grab bar padding identified as uncleanable has been removed (R11 and R82). Alternative padding that is cleanable is being utilized. The full facility audit has been completed and uncleanable padding on grab bars have been removed and/or replaced. The administrator and/or designee are responsible for ongoing compliance. Date certain for ongoing compliance is 12/31/13.	

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(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 441	Continued From page 36 hands after removing the gloves during pericare. During an interview with the director of nursing and administrator on 11/21/13, at 8:30 a.m. both stated their expectation of staff was to wash their hands between gloves changes or use hand sanitized in between, depending on what cares the staff was providing. During an interview with registered nurse (RN)-E on 11/21/13, at 8:55 a.m. RN-E stated the expectation was staff should be washing their hands in between, and before/after changing gloves. The Glove Technique (Non-sterile) policy dated 2010, directed staff to, "Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other resident or environments." R11 and R82 had uncleanable padded grab bars on their beds used for turning/repositioning. On 11/18/13, at approximately 4:34 p.m. observed R11's bed had grab bars on both sides in the up position. Both grab bars were padded with black foam secured with white tape that was ripped off and there was built-up dirt trapped on the foam. In addition R82's right hand grab bar was padded with the same black foam and there were white patches with debris trapped making the padding an uncleanable surface.	F 441		

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 _____	11/21/2013

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 441	Continued From page 37 During an interview conducted on 11/21/13, at 8:42 a.m. with the maintenance director verified the padding on R11 and R82's grab bars did not provide a cleanable surface in the current condition. The mainitenance director further stated, would contact the staff person responsible for doing the padding and would replace the padding as soon as possible. During an interview conducted on 11/21/13, at 9:25 a.m. RN-G stated was not aware of the padding issue but would update maintenance department immediately. The facility policy and procedure related to cleaning padded grab bars was requested, however, it was not provided.	F 441		

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 _____	**11/20/2013**

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
K 000	INITIAL COMMENTS 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. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 208 beds and had a census of 204 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET. *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**11/20/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 208 beds and had a census of 204 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET. *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7760

December 9, 2013

Ms. Maria Garrity, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, Minnesota 55112

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5424023

Dear Ms. Garrity:

The above facility was surveyed on November 18, 2013 through November 21, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File