DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: FB66

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY	<i>T</i>	Fac	ility ID: 009	975
MEDICARE/MEDICAID PROVID (L1) 245424	DER NO.	3. NAME AND AI (L3) PRESBYTE			EN HILLS		OF ACTION:	<u>7 (</u> L8)	
2.STATE VENDOR OR MEDICAID (L2) 369842400	NO.	(L4) 3220 LAKE (L5) ARDEN HI		OULEVAR	(L6) 55112	1. Initia 3. Term 5. Valid	ination lation	 Recertific CHOW Complaint Other 	
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA		Survey After Co		
6. DATE OF SURVEY 01/1. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	3/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		EAR ENDING :	DATE: ((L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	208 (L18) 208 (L17)	1. A B. Not in Cor	ance	gram	And/Or Approved Waivers 2. Technical Person 3. 24 Hour RN 4. 7-Day RN (Rura 5. Life Safety Code * Code: A		g Requirements Scope of Servic Medical Directo Patient Room Si Beds/Room	es Limit or	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS				
18 SNF 18/19 SNF 208 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1)):	(L15)		
16. STATE SURVEY AGENCY REM See Attached Remarks				DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGEN	NCY APPROVAL		Date:	
Susanne Reuss, Unit S	Supervor	(01/13/2013	(L19)	Anne Kleppe, En	forcement	Specialist	t 4/10/20)14 (L20
PA	RT II - TO BE	COMPLETED 1	BY HCFA RI	EGIONAI	L OFFICE OR SINGL	E STATE AGI	ENCY		
19. DETERMINATION OF ELIGIBITED 1. Facility is Eligible to 2. Facility is not Eligible 1.	Participate		MPLIANCE WIT HTS ACT:	H CIVIL	21. 1. Statement of 12. Ownership/Co3. Both of the A	ontrol Interest Disc	` '	CFA-1513)	
22. ORIGINAL DATE	23. LTC AGREE	MENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTI	ON:	(L30	0)	
OF PARTICIPATION 02/01/1987	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reiml	00_	INVOLUNTA 05-Fail to Mee 06-Fail to Mee	t Health/Safe	ty
(L24) 25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions:	(L25) (L44) (L45)		03-Risk of Involuntary Termin 04-Other Reason for Withdra		OTHER 07-Provider St 00-Active	J	
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS				
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32 (L32)	2. DETERMINATION 02/07/2014	N OF APPROVAI	L DATE (L33)	DETERMINATION A	PPROVAL.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

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.



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, Enforcement Specialist Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health Telephone: (651) 201-4124

Done Klegge

Fax: (651) 215-9697

cc: Licensing and Certification File



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

Presbyterian Homes Of Arden Hills

Page 2

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245424	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/13/2014
Name	of Facility		Street Address, City, State, Zip Code	
PF	RESBYTERIAN HOMES OF ARDEN F	HILS	3220 LAKE JOHANNA BOULEV	ARD

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).

ARDEN HILLS, MN 55112

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	((Y5)	Date
ID Prefix Reg. # LSC	F0241 483.15(a)		Correction Completed 12/31/2013	ID Prefix Reg. # LSC	F0246 483.15(e)(1)		Correction Completed 12/31/2013		ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 12/31/2013
ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 12/31/2013	Reg. #	F0315 483.25(d)		Correction Completed 12/31/2013		Reg. #	F0356 483.30(e)		Correction Completed 12/31/2013
ID Prefix Reg. # LSC	F0371 483.35(i)		Correction Completed 12/31/2013	ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 12/31/2013		Reg. #			
ID Prefix Reg. # LSC	-			Reg. #					ID Prefix Reg. # LSC	-		
ID Prefix Reg. # LSC				Reg. #								
Reviewed E	Зу	Reviewed	Ву	Date:	Signatui	re of Sui	veyor:				Date:	
State Agen		SR/AK	•	03/14/2	014				16	6022	01/1	3/2014
Reviewed E	Зу	Reviewed	Ву	Date:	Signatui	re of Sui	veyor:				Date:	
Followup t	o Survey Co 11/2	mpleted on 1/2013	1:							Summary of the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: FB66

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART I -	TO BE COMPI	LETED BY	THE STAT	TE SURVEY AGENCY	Facility ID: 00975
MEDICARE/MEDICAID PROVIDER NO. (L1) 245424 2.STATE VENDOR OR MEDICAID NO. (L2) 369842400	3. NAME AND AI (L3) PRESBYTE (L4) 3220 LAKE (L5) ARDEN HII	CRIAN HOME JOHANNA B	S OF ARD		4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 11/21/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 208 (L18) 13. Total Certified Beds	Complianc X 1. A B. Not in Con		gram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: B*	7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 208 (L37) (L38) (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICATION OF SEE Attached Remarks 17. SURVEYOR SIGNATURE	ABLE SHOW LTC CA	ANCELLATION	DATE):	18. STATE SURVEY AGENCY	Y APPROVAL Date:
Mary Beth Lacina, HFE NE II	1	2/23/2013	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 02/06/2014 (L20
PART II - TO BE	COMPLETED I	BY HCFA R	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		IPLIANCE WIT HTS ACT:	H CIVIL		nncial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNING 02/01/1987 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNATI		4. LTC AGREE ENDING DA (L25)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	05-Fail to Meet Agreement 1NVOLUNTARY 05-Fail to Meet Agreement
A. Suspensio	n of Admissions: uspension Date:	(L44) (L45)		04-Other Reason for Withdrawal	
28. TERMINATION DATE: 29 (L28)	9. INTERMEDIARY/ 03001	/CARRIER NO.	(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539 32 (L32)	2. DETERMINATION	N OF APPROVA	L DATE (L33)	DETERMINATION APP	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

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.



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;

Potential Consequences - 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,

Dore Klegepe

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

PRINTED: 12/09/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245424	B. WING			11/	21/2013	
	PROVIDER OR SUPPLIER	ARDEN HILLS		3220	ET ADDRESS, CITY, STATE, ZIP CODE LAKE JOHANNA BOULEVARD EN HILLS, MN 55112			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	TS	FO	000				
	as your allegation Department's acce bottom of the first be used as verifica Upon receipt of ar revisit of your facil validate that subst	of correction (POC) will serve of compliance upon the eptance. Your signature at the page of the CMS-2567 form will ation of compliance. In acceptable POC an on-site ity may be conducted to cantial compliance with the even attained in accordance with	The state of the s	(A)				
F 241 SS=E	your verification. 483.15(a) DIGNIT INDIVIDUALITY The facility must p manner and in an	Y AND RESPECT OF promote care for residents in a environment that maintains or esident's dignity and respect in	F	241	F241 Education will be completed was for residents with dignity included communication techniques for the second complete	uding		
	full recognition of This REQUIREM by: Based on observ review, the facility personal care exp (R29, R152, R19 others for activitie failed to provide a 2 of 2 residents (I dining room. Findings include: R29 did not recei cares throughout were being perfo 11/20/13.	his or her individuality. ENT is not met as evidenced vation, interview, and document valid failed to provide a dignified perience for 3 of 5 residents 1) observed dependent on eas of daily living. The facility also a dignified dining experience for R251, R223) observed in the	13/3	3/13 ER	Education on lift procedures to explanation of procedure. Sur Classes provided by facility be 12/17/13 and ongoing and/or supervisor using Survey Follow beginning on 12/16/13 and or has also been initiated through staff meetings). Upon notification of these insurvey team, the involved stare-educated regarding follow and My Best Day.	rvey Folginning by indiwup Pangoing. The Standers of the stances o	llow-up on vidual cket Education I-Up (daily by the ber(s) were	

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.

Event ID: FB6611

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245424	B. WING			11/2	21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		32	REET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	During continued of 12:05 p.m. R29 had from breakfast which Nursing assistant (room and without it are going to chang mechanical lift sling saying what was has scream out in protect came into the room talked about this, we position so your skeed crying but did allow bed for position characterized by sischizophrenia (me breakdown of thou emotional respons	bservation on 11/20/13, at don the clothing protector ch was finished at 9:30 a.m. NA)-B and NA-C came into the ntroductions NA-C said, "We e you." NA-B started to put the g behind R29's back without appening next. R29 began to est. Licensed practical nurse in and stated, "[R29] we have we need to change your in does not get sore." R29 was with the staff to transport her to range and incontinence care. If R29 where to put her arms or when the mechanics of the e taking place in raising her out ain in lowering the lift onto the ntinent of urine and loose. NA-B informed R29 the spray care was cold as it was cursing assistants failed to to of each step in the process to the turning in the bed which way thosis from the plan of care lists eral vascular disease and pecific muscle disorders, eural disorders (a chronic		241	Dignity audits while staff are procare will be completed on 5% of weekly for four weeks and then for 2 months. Results of the audits will be revifacility QA committee. Action prodeveloped as needed. The Dining Room Protocol was rupdated. All nursing staff will reregarding the updated via Surve Classes provided by facility beging 12/17/13 and ongoing and/or besupervisor using Survey Followbeginning on 12/16/13 and ong For sustainability of Dining Room facility has integrated additionanew hires implemented on 12/10 ongoing. Random dining room audits will on weekly basis for 4 weeks and	resider 5% of r ewed w lans wil reviewe ceive ec ry Follow nning o ry individuo p Pack oing. m Proto I trainin L6/13 an	esidents with the l be d and ducation w-up n dual tet col ng for nd
		15 out of a possible 15 which	THE REAL PROPERTY AND ADDRESS OF THE PERSON				SERVICE AND ADDRESS OF A STREET

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			E CONSTRUCTION		SURVEY PLETED
		245424	B. WING			11/:	21/2013
PRESBY	PROVIDER OR SUPPLIEF			32	TREET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	R29's plan of care to "Educate me, m possible outcome treatment or care record. Encourage possible during ca explanation of all they occur during R152 was not info during observation nursing assistant (NA)-D. During continuous 4:15 p.m. until 5:0 wheel chair with a was participating in During interview a "Sometimes I sit a becomes tired." At 7:00 p.m. NA-E tired, do you want stated, "No, I wou There were no off reposition R152 of toileting/reposition. The principal diaginarily and impaired motions.	e skills are independent and ent/reasonable. I dated 12/30/11, directed staff by family or caregivers of a (s) of not complying with and document in my medical erne to participate as much as the activities. Give me clear care activities prior to any as each contact. I med of the importance for care to an on 11/18/13 at 7:00 p.m. from 0 p.m. R152 was seated in a pressure relieving cushion and to an activity in the day room. It 5:00 p.m. R152 stated, along time and my butt to 5:30 p.m. R152 was wheeled for supper. At 6:45 p.m. R152 the day room to watch television. It is stated to R152, "You look to go to bed?" to which R152 the contact of a statempts to toilet or to explain the importance of a	F	. "	times 2 months to ensure compli- updated Dining Room Protocol. All nursing staff will receive educe regarding the communication who direct cares via Survey Follow-up provided by facility beginning on ongoing and/or by individual sup Survey Follow-up Packet beginning and ongoing. Audits will be reviewed at Quality meeting for direction, change, or based on compliance results. The administrator and/or designed responsible for ongoing complian Date certain for ongoing complian 12/31/13.	cation nile prov Classes 12/17/2 ervisor ng on 12 y Assura continu	riding 13 and using 2/16/13

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		TE SURVEY MPLETED
		245424	B. WING	······································		11	/21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		3220	EET ADDRESS, CITY, STATE, ZIP CODE DLAKE JOHANNA BOULEVARD DEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 241	R152's BIMS was a indicates Cognitive and is rarely/never R152's plan of care impaired cognitive plan of care directed me, family or cared capabilities and ne routine consistent.	dementia with delirium. an 8 out of a possible 15 which skills are severely impaired able to make decisions. a dated 12/27/11, read; I have function due to dementia. The ed staff to; Communicate with givers regarding residents eds as needed. Keep my and try to provide consistent the as possible in order to	F 2	41			
	During observation NA-A and NA-B cat bathroom (BR). NAR 191 who they we do for R191. The Naposition the mechalift sling without exsaying, "I don't was sling was green ar use was offered.)" raise R191's arms R191 stated, "It hus hurting my legs.' Napold on, hold on," where to position if the sling and the napolain about the complain about the	rmed in a dignified manner ing performed. I on 11/20/13, at 10:05 a.m. me to assist R191 to the A-A and NA-B did not explain to re or what they were going to NA's were attempting to anical lift and to apply the green plaining the sling. R191 was not to use the green one." (the d no simple explanation for it's The NA's were attempting to to adjust for the sling and rts, your hurting me, your A-B was saying, "ok, ok, ok, NA's did not inform R191 his arms for the transfer with the echanical lift and did not hey went to raise or lower the he resident. R191 continued to perform the NA's did not inform R191. The NA's did not inform R191. The NA's did not inform R191.					

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 afteration 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		EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
PRESBYTERIAN HOMES OF ARDEN HILLS X230 LAKE JOHANNA BOULEVARD ARDEN HILLS 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MM 56112			245424	B. WING		11/	21/2013		
FREETX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		PRESBYTERIAN HOMES OF ARDEN HILLS			220 LAKE JOHANNA BOULEVAR	CODE			
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 atteration 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	PREFIX	(EACH DEFICIENT	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	COMPLETION		
Tran were to have cares explained by stain.	F 241	the resident he was ay, "Go now." Nowere going to use and buttocks and process and atter wipe while suspen hear NA-B and haw then the NA's was for R191 to be pure hurts, it presses on NA-B was saying "It is not ok, it hur R191's BIMS date 4 out of a possible were severely impure to make decision read, "COMMUN each interaction make eye contact understand consistences." R19 wears a hearing a The principal diaglisted unspecified disease (CVA) will disorder. R191's have alteration in vascular ulceration. Rt (riglower leg. I need turn/reposition in When interviewed clinical coordinate."	as sitting on the toilet but did A-B did not inform R191 they a cold wet wipe to his scrotum R191 was startled by the mpted to move away from the nded in the sling. R191 could not ad to say several times, "What?" ere lowering the mechanical lift it to bed, R191 was saying, "It on my legs. what are you doing.", "ok, ok, ok," and R191 yelled, its me!" ed 8/28/13, indicated a score of e 15 indicating cognitive skills paired and was rarely/never ables. The care plan dated 12/29/11 ICATION: Identify yourself at Face me when speaking and it. Reduce any distractions. I istent, simple, directive in has hearing difficulty and aide in the right ear. gnoses from R191's care plan I late effect cerebral vascular ith other persistent mental care plan dated 4/3/12, read, "I is skin integrity evidenced by on related to decreased ght) inner heel and L (left) outer assistance of one to bed and wheelchair." d on 11/20/13, at 12:15 p.m.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION		E SURVEY PLETED
		245424	B. WING			11/:	21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		3220	ET ADDRESS, CITY, STATE, ZIP CODE LAKE JOHANNA BOULEVARD EN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED OF THE	D BE	(X5) COMPLETION DATE
F 241	The facility undated "Dementia Care Transcription wife to Introduce yourse Make good eye corresponding for each interesteps. Explain what instructions and question of the facility of the fac	age 5 If training program titled; aining" and "Enhancing the the Resident" directed staff elf to the resident each time, intact, be aware of body ed, patient and calm. Ito your mood. Allow enough action, Break down tasks into t you are doing, repeat estions at least twice exactly in the becondescending.	F 2	141			
	experience for R25 sheet indicated a d During breakfast d 11/20/13, at 9:45 a at the dining room front of her. Nursir cart full of dirty dist from R251. The bujuice mixed together esidents's breakfa approximately two the bucket of discardent breakfast. tissue. While stand discarded food and During interview or community coordinexpectation was the	o provide a dignified dining in Review of R251's face diagnosis of dementia. Ining room observation on .m. R251 was observed sitting table with the breakfast meal in a assistant (NA)-I placed a nes approximately two feet acket half full of water, milk and er, discarded from other ast, was placed on a chair feet away from R251. NA-I left arded fluids and cart of dirty a location while serving another R251 covered her nose with a ding next to R251 an odor of diseverages was noticeable. In 11/21/13, at 12:39 p.m. the nator (CC)-C reported the e cart of dirty dishes and laced further away from dining		·			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245424	B. WING	,	Marie State Marie	11/2	21/2013
	ROVIDER OR SUPPLIER	ARDEN HILLS		32	REET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112	decompany and a second	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 241	4/29/10, directed so settings as needed	age 6 ng Room Protocol dated taff, "10. Bus residents place I." No further directions were acement of food waste from	F2	241	•		
	experience for R22 sheet indicated a day and at 10:00 a.m. NA-I of food/beverage wapproached R223, table, grabbed R22 holding onto R223' gloved hands, asked water. R223 stated the glass of water of During interview or	o provide a dignified dining 23. Review of R223's face liagnosis of dementia. ining observation on 11/20/13, was observed clearing tables vaste and dirty dishes. NA-I seated at the dining room 23's glass full of water. NA-I is glass of water with soiled and if R223 still wanted the I did want the water. NA-I put down and R223 drank it.					
F 246 SS=D	residents were finite and food were clear and food were clear the Dining Room as procedure, "8. It dining, offer wipes protector and crum Record food/fluid oplace setting as ned directed staff to but residents were finite 483.15(e)(1) REAS OF NEEDS/PREFI	Protocol dated 4/29/10, listed When residents have finished and offer to remove clothing abs from their clothing. 9. consumption. 10. Bus residents reded." The procedure is place settings only after the shed dining.	The state of the s	246			
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		E SURVEY PLETED		
		245424	B. WING			11/:	21/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	ARDEN HILLS			20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 246	services in the facil accommodations of preferences, excep	~	F2	. 1	246	lē	131/13
	endangered.	iei residents would be		fo	ne process for identifying the res r assistance at meal time was rev odated for the 4 th floor mealtime	viewed a	eds and
	by: Based on observal review, the facility to feel meals was provious observed during diothers for assistant Findings include: On 11/20/13, durin	g breakfast meal observations 1 was not served breakfast for		The Dining Room Protocol was reviewed and updated. All nursing staff will receive educati regarding the updated Dining Room Protocol Survey Follow-up Classes provided by facility beginning on 12/17/13 and ongoing and/or bindividual supervisor using Survey Follow-up Packet beginning on 12/16/13 and ongoing. Education has also been initiated through Stand-Up (daily staff meetings).			ation col via ty r by
	assessment dated needing extensive activities of daily live During the breakfar floor dining room of was wheeled by a room for breakfast administered media glass of water, Raway and the glass 8:25 a.m. to 9:00 at to her lips trying to empty glass. No of beverages to R21.	nimum Data Set (MDS) 09/18/13, identified R21 as assistance of two staff with all ving, including eating. st meal observations on fourth on 11/20/13, at 8:00 a.m. R21 staff member into the dining a. At 8:25 a.m. a nurse cations to R21 and handed her ical drank all of the water right is was empty. However, from a.m. R21 kept placing the glass drink more water from the one offered any other There were two other e eating their breakfast at the		on tim	ndom dining room audits will be weekly basis for 4 weeks and the les 2 months to ensure complian dated Dining Room Protocol.	en mont	ted hly

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		245424	B. WING _		11/	21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP CO 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112		
(X4) ID PREFIX . TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 246	table, R21 would losip from the empty member asked nur R21 out of the dining rostated, "I don't knoroom, there is no hadining room," and I fish tank next to so a.m. NA-G wheele obtained a breakfar R21. R21 sat and eat/drink breakfast before anyone ser assisted R21 to eat	ok at them and try to take a glass. At 9:00 a.m. a staff sing assistant (NA)-G to take a groom. NA-G wheeled R21 om. When asked NA-G who put her in the dining elp to feed her right now in the eft R21 sitting in front of the auth nursing station. At 9:05 d R21 back to the dining room, st tray, and started feeding watched other residents for approximately one hour yed R21 her breakfast and	F 2	Audits will be reviewed at Que meeting for direction, change based on compliance results. The administrator and/or de responsible for ongoing com	e, or continu signee are pliance.	
F 282 SS=E	registered nurse (F coordinator (CC)-A indicated fourth flo during meal times cognitively impaire from staff. They in from other floor staneeded assistance. They said their exproom was to be obsupervision to the stated they served came to the dining preferred to sleep should not wait in extended period of sit and sip on a be confirmed R21 did with the breakfast	RN)-D and community on 11/20/13, at 9:40 a.m. they or dining room was very busy and many residents who were dineeded meal time assistance adicated they asked for help aff during meal times to provide to the complex residents. Decetation of staff in the dining servant and provide residents. RN-D and CC-A breakfast as the residents room since some residents in late. They added, a resident the dining room for an fitme unless they requested to verage. RN-D and CC-A not receive timely assistance meal on 11/20/13.		282		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245424	B. WING		11	/21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP (3220 LAKE JOHANNA BOULEVARI ARDEN HILLS, MN 55112	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	must be provided accordance with e care. This REQUIREME by: Based on observareview, the facility 3 of 5 residents (Repositioning and Findings include: R29 did not receive every two hours of before and after material and to, "Reposition back every two houses of two wheelchair every two houses is tance of two wheelchair every the directed staff to, "undergarment and meals and after materials and after materials. The materials are materials and after materials and after materials and after materials. The materials are materials and after materials and after materials and after materials and after materials. The materials are materials and after materials and after materials and after materials and after materials. The materials are materials and after materials.	ded or arranged by the facility by qualified persons in ach resident's written plan of ach resident's written plan for 129, R152, R50) observed for toileting/incontinence needs. The assistance with repositioning resident of the care ach according to the care plan also check my incontinent ach ach ach according to the care plan also check my incontinent ach ach ach according to the care plan also check my incontinent ach ach ach ach according to the care plan also check my incontinent ach ach according to the care plan also check my incontinent ach ach according to the care plan also check my incontinent ach ach according to the care plan also check my incontinent ach according to the care plan also check my incontinent ach according to the care plan also check my incontinent ach according to the care plan also check my incontinent ach according to the care plan also check my incontinent according to the care plan also check my incontinent according to the care plan also check my incontinent according to the care plan also check my incontinent according to the care plan acco	A CONTRACTOR CONTRACTO	F282 Care plan policy was revie accurate. Upon notification of these survey team, the involved re-educated regarding fol and My Best Day. Residents R 29 and R 152 comprehensively assessed R191 were comprehensive bowel and bladder. Education will be complete for residents in accordance as communicated via My B of Care via Survey Follow-uby facility beginning on 12, and/or by individual super Follow-up Packet beginning ongoing. Education has also through Stand-Up (daily states)	e instances by a staff member lowing the care of the c	the r(s) were re plan R 50 and for on caring e plan or Point vided regoing rvey and
		60 p.m. (3 hours and 15 repositioning or incontinence				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245424	B. WING			11/2	21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		32	REET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 282	care. During conting from 8:30 a,m. untiminutes). R29 was offer of position chaincontinence. When interviewed p.m.clinical coording (LPN)-B verified R2 change every two before and after mand every two hours and when care plan. R152 did not recei repositioning or too two hours and when care plan. R152's care plan of have potential for plan to immobility, while awake. I have due to impaired mand every two hours. Continuous observition from 4:15 p.m. untiminutes).	uous observation on 11/20/13, il 12:05 p.m. (3 hours and 35 up in a wheelchair without an ange or check/change for on 11/20/13, at 12:15 nator licensed practical nurse 29 was to have a position hours and incontinence care eals. In the pressure with leting (incontinence care every en necessary according to the lated 7/15/13, directed staff, "I pressure ulcer development Reposition every two hours the bladder/bowel incontinence obility. Offer toilet upon arising	F 2	282	A comprehensive care plan revice completed for R29, R152, R191 ensure plan of care and resider consistent. Random audits to address folloplan will be completed on 5% oweekly for four weeks and therefor 2 months. Audits will be reviewed at Quameeting for direction, change, based on compliance results. The administrator and/or design responsible for ongoing compliance certain for ongoing cert	I, and R5 nt needs owing the of resider n 5% of r lity Assur or conting gnee are iance.	O to are e care nts residents
	reposition or toilet observation of R19 until 9:45 a.m. (2 hwere no offers or a R152.	R152. During continuous 52 on 11/20/13, from 7:00 a.m. nours and 45 minutes), there attempts to reposition or toilet rsing assistant (NA)-B and at 9:45 a.m. confirmed R152			·		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245424	B. WING			11/	21/2013
	PROVIDER OR SUPPLIER TERIAN HOMES OF			32	REET ADDRESS, CITY, STATE, ZIP COD 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	When interviewed clinical coordinator (LPN)-B verified R change every two incontinence care The facility policy of "Care Plan Policy plan will ensure the required to maintal highest level of prostep 10 of the polichanged and updaresident and as the be written on the predical record. It R50 was incontine for pressure ulcers followed for reposent 1/20/13, from 7:1 continuous observed. R50's incontinence directed staff R50 bladder. R50 use which were needed "before meal, with needed)," during to check and char and last rounds and R50 clean and dry dated 7/15/13, indical alteration in skin in	on 11/20/13, at 12:15 p.m. Ilicensed practical nurse 152 was to have a position hours and toileting with every two hours. Idated August 2010, and titled and Procedure" read, "The care e resident the appropriate care in or attain the resident's acticable function possible." cy read, "The care plan is to be ated as the care changes for the e resident changes occur it will paper care plan in the resident's is to be current at all times." Int of bowel and bladder, at risk is, and the plan of care was not itioning and toileting needs on 5 a.m. until 9:50 a.m. during rations. The care plan dated 7/15/13, was incontinent of bowel and d disposable incontinent briefs and to be checked and changed, Hs (bedtime) care and prn (as he night shift staff were directed nge R50's brief, "during 1st, 3rd and PRN (as needed)," to keep of R50's skin integrity care plan icated R50 was at risk for integrity; needed assistance of		282			
		nd reposition every two hours Oue to limited physical mobility	Administ's desired?				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY IPLETED
		245424	B. WING			11/	21/2013
	PROVIDER OR SUPPLIER			322	REET ADDRESS, CITY, STATE, ZIP CODE O LAKE JOHANNA BOULEVARD DEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	Continued From p	age 12	F2	82			
		stance of two staff with ed a wheelchair propelled by	The state of the s				
	was sitting in a whrelieving cushion sling. At 8:00 a.m to the dining room beverages and a juice, water and to a.m. the breakfas after set-up R50 b was taken to her watching televisio remained opened (NA)-K and (NA)-lift (mechanical lift bed. R50's inconsee if it needed to assistant before to NA-K returned to R50's incontinent brief was saturated buring an intervier on 11/20/13, at 9: was last checked sometime just be every two hour so check pad becauwill go there now, resident first." At change R50's pad	ew with registered nurse (RN)-E					
	NA-K returned to R50's incontinent brief was saturated on 11/20/13, at 9: was last checked sometime just be every two hour so check pad because will go there now, resident first." At change R50's page	R50's room to check/change se brief. R50's incontinence ed with urine and stool. www.ith nursing assistant (NA)-K44 a.m. NA-K confirmed R50 /changed and repositioned fore 7:00 a.m. and was on an chedule. NA-K added, "I did not se people were in there, but I let me check on this other 9:50 a.m. NA-K check and d.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		SURVEY
		245424	B. WING			11/2	21/2013
	PROVIDER OR SUPPLIER TERIAN HOMES OF	ARDEN HILLS		32	REET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	expectation of nurs the cares as listed Best Day" nursing a were posted in eac	age 13 ing aide staff was to provide on the care plan and in "My aide assignment sheets, which h room and also kept at the	F	282			
F 314 SS=E	nursing desk. 483.25(c) TREATM PREVENT/HEAL F	TENT/SVCS TO PRESSURE SORES	· F	314			·
•	resident, the facility who enters the faci does not develop p individual's clinical they were unavoidal pressure sores rec	orehensive assessment of a must ensure that a resident dity without pressure sores bressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and the healing, prevent infection and from developing.			F314 The Policy and Procedure for reviewed and remains accura		12/31/13 sk was
	by: Based on observa review, the facility every two hours fo	NT is not met as evidenced ation, interview, and document failed to provide repositioning r 4 of 5 residents (R29, R152, yed who were at risk for skin			Upon notification of these in survey team, the involved stare-educated regarding follow and My Best Day.	aff mem	ber(s) were
	receive assistance on 11/18/13, from hours and 15 minu 8:30 a.m. until 12:0 minutes).	skin breakdown and did not to reposition every two hours 4:15 p.m. until 7:30 p.m. (3 ttes) and on 11/20/13, from 05 p.m. (3 hours and 35	The second section of the second seco		A Comprehensive Skin Assess completed for R29, R152, R1 ensure plan of care and resid consistent.	91, and	R50 to
		observation on 11/18/13, from p.m. R29 was seated in a		egements replications			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	B. WING		11/21/2013
NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF A	RDEN HILLS	3	TREET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112	
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
place. At 4:15 p.m. I watching television a p.m. R29 was taken and required feeding R29 was wheeled b front of the television seated in the wheele or attempts to change assistance with eati returned to the bedit television sitting in the observations R29's could watch out into television. At 12:05 and NA-C came with change R29's posit R29's skin and thigh craters and crevice brief. The areas we were the quarterly Minim 8/21/13, indicated for two staff for bed for developing presiturning/repositionin. R29's principal diagonal plan dated 8/20/13, vascular disease. Other specific musc myoneural disorder neuromuscular disorder in the plan to the period of the specific musc myoneural disorder neuromuscular disorder in the period of the pe	ressure relieving cushion in R29 was in the bedroom and eating a cookie. At 5:15 to the dining room for supper g assistance. At 6:45 p.m. ack to the bedroom and set in m. At 7:30 p.m. R29 remained chair and there were no offers ge R29's position. Observation on 11/20/13, R29 lchair at 8:30 a.m. and g room at 8:35 a.m. At 9:03 and R29 received ing. At 9:30 a.m. R29 was room and resumed watching the wheelchair. During all door remained open and R29 to the hallway as well as watch p.m. nursing assistant (NA)-B th the mechanical lift to ion. Upon removal of the brief, his had numerous deep red is from the wrinkling of the gree blancheable at the time.	fc a: o b: a: Fc o th R p w fc A m b		e care plan and/or Point s provided and ongoing ag Survey 16/13 and aitiated aings). g the care sidents of residents Assurance ontinuation are

		FOF DEFICIENCIES DE CORRECTION	(X1) PRÓVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
PRESBYTERIAN HOMES OF ARDEN HILLS (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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)			245424	B. WING			11	/21/2013
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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)			ARDEN HILLS		322	0 LAKE JOHANNA BOULEVARD		
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."	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
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	disorder characterity processes and by i unspecified condition 8/20/13, read, "I had development r/t (real Immobility" and directly and directly and directly and the I'm up in it. I in turn/reposition in behours. If I refuse the (interdisciplinary tewhy and try alternate compliance. Resident. Staff to at R29's Brief Intervied dated 8/21/13, indispossible 15 (cognitive decisions consisted Braden Scale for Pland dated 2/19/13, currently for development. Braden Scale for Pland dated 2/19/13, currently for development and interview NA-B confirmed the position change even R152 was at risk for receive assistance on 11/18/13, from Alburs and 15 minutes). During continuous 4:15 p.m. until 5:00	zed by a breakdown of thought mpaired emotional responses) on. R29's plan of care dated eve potential for pressure ulcer plated to) Hx (history) of ulcers, ected staff to, "Reposition me: chair) back every two hours need assistance of two to ed and wheelchair every two eatment confer with me, IDT am) and family to determine entitive methods to gain ent is resistive to repositioning. We been explained to family & tempt reapproaching." Ew for Mental Status (BIMS) cated a score of 15 out of a tive skills are independent and ent/reasonable). The form titled Predicting Pressure Sore Risk indicated moderate risk oping pressure ulcers. In on 11/20/13, at 12:15 p.m. ere should have been a very two hours for R29. For skin breakdown and did not to reposition every two hours 4:15 p.m. until 7:30 p.m. (3 intes); and on 11/20/13, from 5 a.m. (2 hours and 45	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LTIPLE CONSTRUCTION DING	(X3	(X3) DATE SURVEY COMPLETED	
		245424	B. WING		***	11/21/2013	
	PROVIDER OR SUPPLIER	ARDEN HILLS		STREET ADDRESS, CITY, STATE, 2 3220 LAKE JOHANNA BOULEV ARDEN HILLS, MN 55112		102013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIAT		
F 314	was participating in During interview at "Sometimes I sit a becomes tired." At to the dining room was wheeled to the At 7:00 p.m. NA-D tired, do you want to stated, "No, I would There were no offer R152 or to explain change. During continuous 11/20/13, from 7:00 wheelchair via meet the bedroom watch wheelchair. At 8:20 "Hello, Hello, Hello was wheeled to the 9:35 a.m., after sitt minutes, R152 was 9:45 a.m. NA-B an mechanical stand to buttocks. The QMDS dated to extensive assistant mobility, total assist transfers, was at risulcers and was on program. R152's principal dialisted paralysis agit of the central nervot tremor and impaired."	an activity in the day room. 5:00 p.m. R152 stated, long time and my butt 5:30 p.m. R152 was wheeled for supper. At 6:45 p.m. R152 e day room to watch television. stated to R152, "You look to ge to bed?" to which R152 d like to watch television yet." ars or attempts to reposition the importance of a position observation of R152 on 0 a.m. when transported to the chanical stand and remained in hing television sitting in the 0 a.m. R152 was calling out, here I am." At 8:25 a.m. R152 e dining room for breakfast. At ing for 2 hours and 45 s taken to the bedroom and at d NA-E stood R152 in the to relieve pressure from 8/7/13, indicated R152 required the of two staff with bed tance of two staff with bed	F3	314			
!	diagnoses included	f muscular wasting, disuse dementia with delirium.	***************************************				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	0		E SURVEY PLETED
		245424	B. WING				11/2	21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		322	REET ADDRESS, CITY, STATE, ZIP CO 20 LAKE JOHANNA BOULEVARD DEN HILLS, MN 55112	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 314	indicating cognitive and was rarely/nev form titled "Braden Sore Risk" and data risk. R152's care plan depotential for pressur immobility. Reposition awake." Interviews with NA-9:45 a.m. confirmed changes every two "Skin Risk Policy" and the discussed are resident's medical designee along with updated on resident R191 did not receive repositioning every facility document titused as a "Quick Green was resident of the composition of the compositi	e was 8 out of a possible 15 skills were severely impaired er able to make decisions. The Scale for Predicting Pressure ed 10/26/13, indicated mild ated 7/15/13, read; "I have the ulcer development due to ion every two hours while B and NA-E on 11/20/13, at d R152 was to have position hours. ated December 2010, titled under Education read, "Provide ent and responsible resident refuses treatment or entions the risks and benefits and documented in the record. The physician or hithe responsible party will be nt's refusal."		314	DEFICIENCY			
	R191 complained of assigned to care for	on 11/18/13, at 5:00 p.m. of right leg pain. NA-D or R191 was interviewed about d a position change. NA-D						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONS	STRUCTION			E SURVEY PLETED
		245424	B. WING _				11/2	21/2013
	PROVIDER OR SUPPLIER TERIAN HOMES OF	ARDEN HILLS		3220 LA	ADDRESS, CITY, STATI KE JOHANNA BOULI I HILLS, MN 55112	EVARD	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN (EACH CORRECTIVE / ROSS-REFERENCED T DEFICII	ACTION SHOULD TO THE APPROP	BE	(X5) COMPLETION DATE
F 314	stated, "Maybe at to repositioned for ap	•	F 31	14				
·	8/28/13, indicated I assistance of two sassistance	num Data Set (QMDS) dated R191 required extensive staff for bed mobility,total staff for transfers, was at risk soure ulcers, and was on a g program.						
	4 out of a possible were severely impa to make decisions. for Predicting Pres	d 8/28/13, indicated a score of 15 indicating cognitive skills aired and was rarely/never able The form titled "Braden Scale sure Sore Risk" and dated moderate risk for development				·		
	listed unspecified land disease (CVA) with disorder. R191's can have alteration in subscriptions vascular ulceration circulation. Rt (right lower leg. I need as	noses from R191's care plan ate effect cerebral vascular in other persistent mental are plan dated 4/3/12, read, "I skin integrity evidenced by in related to decreased at) inner heel and L (left) outer ssistance of one to ed and wheelchair."						
	clinical coordinator	on 11/20/13, at 12:15 p.m. LPN-B verified R29, R152 and a a position changes every two		***************************************				
	repositioned every	skin breakdown and was not two hours on 11/20/13, from 3 a.m. (2 hours and 23						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		245424	B. WING			11	/21/2013
	PROVIDER OR SUPPLIER			3220	EET ADDRESS, CITY, STATE, ZIP CODE LAKE JOHANNA BOULEVARD DEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	During continuous 7:15 a.m. until 9:3 wheelchair with a a large green lift s was brought to the required meal set 8:48 a.m. was eith or eating a bananserved and R50 b a.m. R50 was retu watching televisio 9:38 a.m. nursing transferred R50 fronto the bed. At to R50's room to	age 19 s observation on 11/20/13, from 8 a.m. R50 was up in the pressure relieving cushion and ling in place. At 8:00 a.m. R50 edining room for breakfast and up. Between 8:00 a.m. and up. Between 8:00 a.m. and up. drinking water/orange juice a. At 8:48 a.m. breakfast was egan eating after setup. At 9:08 urned to her room and resumed in sitting in the wheelchair. At assistant (NA)-K and NA-L om wheelchair via a mechanical 9:50 a.m. when NA-K returned check/change R50's	F3				
	The quarterly Min 9/25/13, indicated of two staff for ber a turning/reposition R50's Brief Interviscore was 5 out of cognitive skills were rarely/never able to indicated R50's discerebrovascular adiabetes mellitus at R50's Care Area A7/8/13, revealed, 1-2 staff with transcompleting her AE and impaired mobility (cerebrovascular addition, staff need at two staff need and impaired mobility and im	ccident (stroke), depression,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245424	B. WING	******		111	21/2013		
NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF ARDEN HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORREIPERERIX (EACH CORRECTIVE ACTION SHOTAG CROSS-REFERENCED TO THE APPOPER DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 314	4 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.			14					
	addressed R50 as skin integrity; need to turn and reposit needed. Due to lift required 2 staff me	y plan of care dated 7/15/13, s being at risk for alteration in ded 2 staff members assistance ion every 2 hours and as mited physical mobility R50 embers assistance with ed a wheelchair propelled by							
	on 11/20/13, at 9:4 was last reposition	w with nursing assistant (NA)-K 44 a.m. NA-K confirmed R50 ned sometime just before 7:00 an every two hour schedule.							
	on 11/21/13, at 8:6 expectation of nur the cares as listed Best Day" nursing	w with registered nurse (RN)-E 55 a.m. RN-E stated the sing aide staff was to provide on the plan of care and in "My aide assignment sheets and ch room and also kept at the							
	Procedure" dated ensure the resider to maintain or atta practicable function policy read, "The cupdated as the cas the resident children in the re	titled "Care Plan Policy and 8/10, read, "The care plan will at the appropriate care required in the resident's highest level of an possible." Step 10 of the care plan is to be changed and re changes for the resident and anges occur it will be written on n in the resident's medical							

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
PRESBYTERIAN HOMES OF ARDEN HILLS (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			245424	B. WING		11	11/21/2013			
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					STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD					
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	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
physician or designee along with the responsible party will be updated on resident's refusal." F 315 483.25(d) NO CATHETER, PREVENT UTI, F 315 SS=D RESTORE BLADDER	F 315	record. It is to be or The facility policy du "Skin Risk Policy" to Positioning indicate individualized turning the resident is im Education read, "Pand responsible parefuses treatment of the risks and benefuses treatment of the risks and benefused in the physician or design party will be updated 483.25(d) NO CAT RESTORE BLADD Based on the resident who enterindwelling catheter resident who enterindwelling catheter resident's clinical or catheterization was who is incontinent treatment and servinfections and to refunction as possible. This REQUIREME by: Based on observative review, the facility to to the facility of the facility o	ated December 2010, titled under Activity, Mobility, and ed, "2. Establish and record and and repositioning schedule mobile." In addition, under rovide education to resident or preventative interventions fits will be discussed and resident's medical record. The nee along with the responsible ed on resident's refusal." HETER, PREVENT UTI, PER ent's comprehensive actility must ensure that a set the facility without an is not catheterized unless the ondition demonstrates that as necessary; and a resident of bladder receives appropriate rices to prevent urinary tract estore as much normal bladder es. NT is not met as evidenced tion, interview, and document failed to check/change or offer hours for 3 of 5 residents (R29, red who were dependent on	F 3	F315 The Bowl and Bladder Assested reviewed and remains accurately to the survey team, the involved streeducated regarding following and My Best Day. A Bowel and Bladder assested completed for R29, R152, and R315.	rate. nstances by the taff member(s) wing the care please sment was and R50 to ensure	were an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245424	B. WING		11/	21/2013	
	PROVIDER OR SUPPLIE TERIAN HOMES OF			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 315	receive assistance two hours or before p.m. until 7:30 p.m. and on 11/20/13, (3 hours and 35 r. During continuous 4:15 p.m. until 7:30 wheelchair with a place. At 4:15 p.m. watching televisic p.m. R29 was taken and required feed R29 was wheeled front of the televis seated in the whore attempts to charber for the different of the before attempts to charber for attempts to charber for the different of the before assistance with ear turned to the before assistance with ear turned to the before for the following returned to the before for the following for the followi	ent of bladder and did not e with incontinence care every re meals on 11/18/13, from 4:15 m. (3 hours and 15 minutes); from 8:30 a.m. until 12:05 p.m. ninutes). s observation on 11/18/13, from 80 p.m. R29 was seated in a pressure relieving cushion in n. R29 was in the bedroom on and eating a cookie. At 5:15 ten to the dining room for supper ding assistance. At 6:45 p.m. d back to the bedroom and set in sion. At 7:30 p.m. R29 remained selchair and there were no offers eck/change R29's incontinence s observation on 11/20/13, R29 eelchair at 8:30 a.m. and hing room at 8:35 a.m. At 9:03 rved and R29 received sating. At 9:30 a.m. R29 was edroom and resumed watching on the wheelchair. During all es's door remained open and R29 into the hallway as well as watch be p.m. nursing assistant (NA)-B with the mechanical lift to ee's incontinence brief. R29's f was saturated with urine and		Education will be completed with for residents in accordance with as communicated via My Best Day of Care via Survey Follow-up Claby facility beginning on 12/17/13 and/or by individual supervisor of Follow-up Packet beginning on 10 ongoing. Education has also been through Stand-Up (daily staff med Random audits to address follow plan related to toileting will be complainted to the form of the following stands of the sidents weekly for four with the following stands will be reviewed at Quality meeting for direction, change, or based on compliance results. The administrator and/or design responsible for ongoing compliance certain for ongoing certain certain for ongoing certain ce	the care pay and/or pay and/or pays and ongo using Surve (2/16/13 and initiated petings). Ving the cacompleted weeks and pay Assurance recontinuations.	elan Point ded bing ey nd re on then	
	8/21/13, indicated of two staff with t	ement. nimum Data Set (QMDS) dated d R29 required total assistance ransfers, extensive assistance of leting, and was always					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		Į.	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245424	B. WING		11/	21/2013
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 315	incontinent of blad R29's Brief Intervie dated 8/21/13, ind possible15 which i independent and o consistent/reasona R29's principal dia dated 8/20/13, liste vascular disease. other specific mus myoneural disorde neuromuscular dis muscle weakness disorder character processes and by unspecified condit 8/20/13, read, "I r bladder/bowel inco Neurogenic disord undergarment and meals and after m (whenever necess Day" dated 11/21/ 2: MUST BE TOIL When in w/c (whe REFUSES."	ew for Mental Status (BIMS) icated a score of 15 out of a ndicated cognitive skills are lecisions able. gnosis from the care plan ed unspecified peripheral. The care plan further listed cle disorders, unspecified ers (a chronic autoimmune corder characterized by skeletal) and schizophrenia (mental fized by a breakdown of thought impaired emotional responses) ion. R29's care plan dated eave FUNCTIONAL continence r/t (related to) ler. Check my incontinent at change upon rising, before eals, at HS (bedtime) and printary)." The form titled "My Best 13, directed staff to, "Assist of ETED EVERY 2 hrs. (hours) elchair) EVEN IF SHE	F 3	315		
	with NA-B and clir practical nurse (LF	w on 11/20/13, at 12:15 p.m. lical coordinator licensed PN)-B confirmed there should k/change of the incontinence urs for R29.	The state of the s			
	receive assistance	or incontinence and did not with toileting every two hours 4:15 p.m. until 7:30 p.m. (3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	:	245424	B. WING			11/:	21/2013
	PROVIDER OR SUPPLIER TERIAN HOMES OF A	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315	hours and 15 minut 7:00 a.m. until 9:45 minutes).	ge 24 les); and on 11/20/13 from a.m. (2 hours and 45 lobservation on 11/18/13, from	F 3	15			
	4:15 p.m. until 5:00 wheel chair with a p was participating in During interview at "Sometimes I sit a I becomes tired." At to the dining room to was wheeled to the At 7:00 p.m. NA-D stired, do you want to stated, "No, I would There were no offer	p.m. R152 was seated in a pressure relieving cushion and an activity in the day room. 5:00 p.m. R152 stated, ong time and my butt 5:30 p.m. R152 was wheeled or supper. At 6:45 p.m. R152 day room to watch television. Stated to R152, "You look or ge to bed?" to which R152 like to watch television yet." rs or attempts to toilet R152 or rtance of a toileting schedule.					
	11/20/13, from 7:00 wheelchair via mec in the bedroom wat R152 was calling of am." At 8:25 R152 room for breakfast, bedroom and at 9:4 R152 in the mechal from buttocks. (2 he and NA-E verified the	bbservation of R152 on a.m.when transported to the hanical stand R152 remained ching television. At 8:20 a.m. ut, "Hello, Hello, Hello here I was wheeled to the dining At 9:35 a.m. was taken to 5 a.m. NA-B and NA-E stood nical stand to relieve pressure ours and 45 minutes). NA-B ney did not check R152 for d not offer toileting to R152 at					
7	8/7/13, indicated R	num Data Set (QMDS) dated 152 required extensive taff with transfers, toileting, ontinent of bladder.					
	R152's BIMS indica	ted a score of 8 out of a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245424	B. WING		11/	21/2013	
	PROVIDER OR SUPPLIER	ARDEN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 315	possible 15 which i severely impaired a make decisions.	ndicated cognitive skills were and was rarely/never able to	F3	315			
	listed paralysis agit of the central nervo tremor and impaire diagnoses included	agnosis in the medical record tans (a degenerative disorder bus system characterized by ad motor coordination). Further dimuscular wasting, disuse dementia with delirium.					
	FUNCTIONAL blace (related to) Impaire (urinary tract infect mobility.	ated 7/15/13, read; "I have dder/bowel incontinence r/t ed mobility, History of UTI ion) Decreased physical ising and every two hours					
	and Bladder Asses individualized toilet for each resident a be developed for in the highest level of possible. The policassistant registered Best Day" will be u	lated 7/10, and titled "Bowel sment Policy" indicated an ing plan would be developed and that the plan of care would nterventions for elimination at bowel and bladder function as by directed, "The NAR (nursing d) assignment sheet or "My pdated to match the plan as per the resident care					
	9:45 a.m. confirme	-B and NA-E on 11/20/13, at d R152 was to have toileting d both verified toileting did not burs.	,				
	clinical coordinator	on 11/20/13, at 12:15 p.m. LPN-B verified R152 was to nedule of every two hours.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
e.		245424	B. WING			11/	21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		3220	EET ADDRESS, CITY, STATE, ZIP CODE LAKE JOHANNA BOULEVARD DEN HILLS, MN 55112	1	a ki ab Q j Q
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	κ ·	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	Continued From pa	age 26	F3	15			
	did not receive ass every two hours on 9:50 a.m. (2 hours continuous observation of 11/20/13, from was sitting in a wherefieving cushion of sling. At 8:00 a.m. to the dining room beverages and a bijuice, water and too the breakfast tray was taken to room and meanwhile the room of 9:38 a.m. nursing a transfered R50 using from the wheelchal incontinent brief was nursing assistant to changed before the NA-K returned to R50's incontinent.	7:15 a.m. to 8:00 a.m. R50 eelchair on top of a pressure overed with a large Hoyer lift a staff member wheeled R50 for breakfast and was provided anana. R50 sipped on orange ok bits of banana. At 8:48 a.m. was served to R50 and after eating. At 9:08 a.m. R50 was started watching television, m door remained opened. At assistant (NA)-K and (NA)-L ang a Hoyer lift (mechanical lift) ir onto the bed. R50's as not checked by either to see if it needed to be eay left the room. At 9:50 a.m. R50's room to check/change orief. R50's incontinence brief					
	9/25/13, indicated of two staff for bed toileting. The QML incontinent of blade Mental Status (BIN out of a possible 19 were severely impate to make decisions. diagnoses included	mum Data Set (QMDS) dated R50 required total assistance mobility, transfers, and DS indicated R50 was always der. R50's Brief Interview for R5) score dated 9/25/13, was 5 indicative of cognitive skills aired and was rarely/never able The QMDS indicated R50's dicerebrovascular accidentin, diabetes mellitus and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245424	B WING			11/2	21/2013
	PROVIDER OR SUPPLIER TERIAN HOMES OF	ARDEN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 315		signment sheet dated 10/7/13,	F3	315			
	closet door in the re reposition and toile needed while awak assignment sheet i R50's incontinent b cares, and 1st and	ys," was posted inside the com and directed staff to t R50 every two hours and as e. In addition, the nurse aide indicated to check and change rief before meals, with evening 3rd rounds during the night 50's skin clean and dry.				•	
	dated 07/2/13, indic needs for toileting a staff needed to anti	dder evaluation documentation cated R50 was unable to make and repositioning known and icipate and follow the care plan 50 every two hours and as	· commence de la comm	The state of the s			
	revealed R50 wore staff needed to che hours and as need to provide perineur	essment (CAA) dated 7/8/13, an extra extra large brief and eck/change the brief every two ed. In addition, staff needed in cares after each incontinent protective cream to promote					
	revealed R50 was bladder, and used plan directed staff i "before meal, with needed)," during th to check and chang	plan of care dated 7/15/13, incontinent of bowel and incontinent briefs. The care to check/change R50's briefs, Hs (bedtime) care and prn (as the night shift staff were directed ge R50's brief, "during 1st, 3rd d PRN (as needed)," to keep					
		with nursing assistant (NA)-K 4 a.m. NA-K confirmed R50					

NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF ARDEN HILLS SITREET ADDRESS, CITY, STATE, ZIP CODE 2220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 DEPAYOFRER PLAN OF CORRECTION STATE AND CORRECTION REQULATORY OR LSC IDENTIFYING INFORMATION) FRETY TAG FRACT SUPPLIER (EACH OPEN LSC IDENTIFYING INFORMATION) FRACT SUPPLIER REQULATORY OR LSC IDENTIFYING INFORMATION) FRACT SUPPLIER FRACT SUPPLIER REQULATORY OR LSC IDENTIFYING INFORMATION) FRACT SUPPLIER FRACT SUPPLIER FRACT SUPPLIER REQULATORY OR LSC IDENTIFYING INFORMATION) FRACT SUPPLIER FRACT SUPPLIER FRACT SUPPLIER FRACT SUPPLIER RECOVERED TAKA OF CORRECTION FRACT SUPPLIER RECOVERED TAKA OF CORRECTION FRACT SUPPLIER FRACT SUPPLIER		ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X0) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLI		· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED	
PRESBYTERIAN HOMES OF ARDEN HILLS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EXCHORENCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 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 is to be changed and updated as the care changes for the resident and as the resident thanges occur it will be written on the paper care plan in 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." The facility policy dated 7/10, and titled "Bowel and Bladder Assessment Policy" indicated an individualized to betting plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resident and the care plan would be developed for each resid			245424	B. WING _		11/21/2013
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 "Gowel and Bladder Assessment Policy" indicated an individualized toleting plan would be developed for each resident threventions for elimination at the highest level of bowel and bladder function as possible. The policy directed, "The NAR (nursing assistant registered) pass ginnent sheet or "My Best Day" will be updated to match the bidetingletiminator plan as pet the resident care			ARDEN HILLS	-	3220 LAKE JOHANNA BOULEVARD	1112172010
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 cocur it will be written on the paper care plan in the resident's medical record. It is to be current at 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 sould 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 tolleting/elimination plan as per the resident care	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
pian."	F 315	was last checked/cl sometime just before every two hour scheck pad because will go there now, le resident first." At 9:: R50's pad which was feces. During an interview on 11/21/13, at 8:56 expectation of nurs the cares as listed of Best Day" nursing a were posted in each nursing desk. The facility docume Procedure" dated 8 ensure the resident to maintain or attain practicable function policy read, "The cupdated as the care as the resident chat the paper care plant record. It is to be cut The facility policy da and Bladder Assess individualized toiletifor each resident and developed for intervhighest level of bow possible. The policiassistant registered Best Day" will be up	manged and repositioned re 7:00 a.m. and was on an edule. NA-K added, "I did not people were in there, but I at me check on this other 50 a.m. NA-K check/changed as saturated with urine and with registered nurse (RN)-E 5 a.m. RN-E stated the ing aide staff was to provide on the care plan and in "My aide assignment sheets, which in room and also kept at the intitled "Care Plan Policy and /10, read, "The care plan will the appropriate care required in the resident's highest level of possible." Step 10 of the are plan is to be changed and a changes for the resident and inges occur it will be written on in the resident's medical urrent art all times." ated 7/10, and titled "Bowel sment Policy" indicated an ing plan would be developed and the care plan would be ventions for elimination at the vel and bladder function as y directed, "The NAR (nursing i) assignment sheet or "My bodated to match the	F 31	5	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245424	B. WING		11/	21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS	. 3	TREET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	_	a rav iv
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 356 F 356 SS=C	483.30(e) POSTEI INFORMATION The facility must per a daily basis: o Facility name. o The current date o The total number by the following caunlicensed nursing resident care per segistered nursident care per segistered nursident care per segistered nursident care per segistered nursident census. The facility must perspecified above on of each shift. Data o Clear and readal o In a prominent persidents and visited. The facility must, unake nurse staffin for review at a costandard. The facility must must persidents and visited the facility must must persident and visited the facility must must persident and visited the facility must must persident and visited the facility must persident and visited the facility must must persident and visited the facility mu	ost the following information on and the actual hours worked tegories of licensed and staff directly responsible for hift: urses. Citical nurses or licensed (as defined under State law). e aides. Ost the nurse staffing data a daily basis at the beginning a must be posted as follows: ole format.	Hoto Se win lie T re N fe v	i i	ed accord n and Hur uirement Posting to ted by rs posted el respon urs Postin ekly for 3 ccuracy. e are ce.	man cs d was nsible
	by: Based on observa failed to post the a	NT is not met as evidenced ition, and interview, the facility ctual hours worked for nursing nsible for resident care per shift	de la constanta de la constant			VA COMPANY CONTRACTOR

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		245424	B. WING	***************************************		11/2	1/2013
	ROVIDER OR SUPPLIER	ARDEN HILLS		32	REET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
/F 356	on 11/18/13, 11/19 This had the poter residents residing	/13, 11/20/13 and 11/21/13. tial to affect visitors and all 203	FS	356		The state of the s	
	the facilty nursing observed in the manursing staff inform worked by the lice	our on 11/18/13, at 11:45 a.m. staff posting on a wall was ain lobby area. The posted nation lacked the actual shifts nsed and unlicensed staff who res to the residents.					
	staff posting forms 11/19/13, 11/20/13 daily shift hours for staff was lacking to shift the staff had 11/21/13, at 3:00 p with the director of was new to him the and unclicensed s	n observations of the nursing is posted in the lobby wall on B, and 11/21/13, it was noted the or the licensed and unlicensed or reflect how many hours each worked on the units. On o.m. these forms were reviewed in fursing (DON) who indicated it eat exact shift hours for licensed staff had to be posted, however, will add the actual shift hours on ow on.	Į.				
F 371 SS=D	11/21/13, at 4:07 confirmed the sta incorrect lacking a licensed and unlice added, "Will fix it 483.35(i) FOOD F		. F	37	13/1		/31/13
		from sources approved or actory by Federal, State or local			The Infection Control Policy/Prod Hygiene was reviewed and rema		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245424	B. WING		11/21/2013	
	PROVIDER OR SUPPLIE TERIAN HOMES OF		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE COMPLETION DATE	
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:			re-educated regarding The Dining Room Proto updated. All nursing sta	ved staff member(s) were this policy. col was reviewed and aff 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		
	dining room on 11 was observed. The gloved hands put FS-B was observed the bottom portion paper towel and withe food cart. FS and touched the caddition, FS-B protemperatures with or wiping the there temperature check.	con meal in second floor South /18/13, 12:45 p.m. the following a food server (FS)-B with food items on resident plates. The detection of the Dutch door, took a wiped the counter/sink next to reached to check food a plate of box of gloves. In proceeded to check food anout sanitizing the thermometer mometer in between food ks, and then took a pen to log cures. While wearing the same		be completed on week then monthly times 2 is compliance with update Protocol. Audits will be reviewed	and kitchenette audits will kly basis for 4 weeks and months to ensure ted Dining Room d at Quality Assurance change, or continuation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		245424	B. WING		41/	21/2013
	PROVIDER OR SUPPLIER	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP O 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	CODE	# 1740 tV
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 371	gloves FS-B touch sink area. FS-B did gloves during the elements of the sink area. FS-B did gloves during the elements of the soup bowl while sepackage of cracked with the same gloves without was food, touched a sed drawer handle and Dutch door. During an interview FS-C verified wore service and chang not wash hands or An interview conduction with NA-J and where washing between we don't normally changes. During an interview and administrator is stated their expects.	ed the food cart next to the dinot wash hands, or change	re D		iance.	
	sanitizer in between the staff was provided. The facility failed to	n, depending on what cares	· · · · · · · · · · · · · · · · · · ·			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		245424	B. WING		14	/21/2013	
	PROVIDER OR SUPPLIER	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP (3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	CODE	12 112013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETION DATE		
F 371	71 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,		F3	771			
	at 10:00 a.m. the nobserved clearing the and dirty dishes. We changing gloves, Note at the dining room of the full of water. NA-I we of water with soiled still wanted the wat	ursing assistant (NA)-I was ables of food/beverage waste lithout washing hands or A-I approached R223's glass while holding onto R223's glass gloved hands, asked if R223 er. R223 stated she did want the glass of water down and	•				
	community coordin touching R223's wa	11/21/13, at 12:39 p.m. the ator (CC)-C reported NA-I ater glass with soiled gloved set the dining room service					
F 441	staff, "Wear clean, touching blood, bod and contaminated i promptly after use, non-contaminated i surfaces, and befor and wash hands immicroorganisms to environments."	dure dated 2010, directed non-sterile gloves when ly fluids, secretions, excretions tems." "Remove gloves before touching tems and environmental e going to another resident, mediately to avoid transfer of	F 4	4			
SS=E	SPREAD, LINENS The facility must es Infection Control Pr	tablish and maintain an ogram designed to provide a omfortable environment and		The Perineal Care Policy an Glove Technique was review accurate.	d Infection Co	i	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245424	B. WING _	1	11/:	21/2013
NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION) BE	(X5) COMPLETION DATE
F 441	to help prevent the of disease and infe (a) Infection Control The facility must est Program under white (1) Investigates, coin the facility; (2) Decides what personal be applied to (3) Maintains a receptactions related to in (b) Preventing Spreactions related to in (b) Preventing Spreactions related to in (c) Preventing Spreactions that a reprevent the spread isolate the resident (2) The facility must communicable diserior direct contact will to (3) The facility must hands after each dhand washing is improfessional practice (c) Linens Personnel must hands after must hand must hands after must hand must hands after must hand must	development and transmission ction. of Program stablish an Infection Control ich it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections. ead of Infection ich Control Program esident needs isolation to of infection, the facility must interpretations or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 44	Upon notification of an instance be team, the involved staff member (seducated regarding changing of gland washing. Education will be completed with reinforcing proper hand washing cares via Survey Follow-up Classes facility beginning on 12/17/13 and and/or by individual supervisor us Follow-up Packet beginning on 12 ongoing. Education has also been through Stand-Up (daily staff meet completed annually in competence Random audits to address following washing and gloves related to percompleted on 5% of residents we weeks and then 5% of residents of Dining room will be completed on for 4 weeks and then monthly ting to ensure compliance in following care.	staff on and peri sprovided ongoin sing Survey (16/13 a initiated etings) a cy class. Ingham hand hand hand hand hand hand hand hand	neal ed by ng vey and d nd is d will be four nths.
	by: Based on observa review, the facility t	NT is not met as evidenced tion, interview, and document ailed to ensure staff followeding to prevent the potential		Audits will be reviewed at Quality meeting for direction, change, or based on compliance results.		- 1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245424	B. WING			11/	21/2013	
NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF ARDEN HILLS			3220 LAK	DDRESS, CITY, STATE, ZIP CC (E JOHANNA BOULEVARD HILLS, MN 55112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	reviewed for urinal bars in 2 of 2 reside have a cleanable standard in 2 of 2 residence and part of the control	ry incontinence. Padded grab lents (R11, R82) rooms did not surface. Inot occur between glove prising assistant when pericare R50 on 11/20/13, at 9:50 a.m. pent of bowel and bladder. To a.m. nursing assistant wed going into R50's room. Pericare for R50 on the pericare for R50. During the pericare for R50 on to R50's bottom. At 9:58 a.m. ed incontinent brief out of R50's coiled ultility room, touched the sposed of soiled incontinence when both hands. The pericare for R50 of R50's are directly assistance and pericare for R50's are directly assistance assistance of 1-2 are positioning, and completing apaired vision and impaired to CVA (cerebrovascular).	F	has bee padding full facil unclear remove. The adding respon	b bar padding identified in removed (R11 and Righthat is cleanable is belity audit has been compable padding on grabiled and/or replaced. In ministrator and/or desible for ongoing compact in the compact is a certain for ongoing compact in the compact is a certain for ongoing compact in the cert	82). Alternat ing utilized. npleted and bars have be ignee are bliance.	ive The	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245424	B. WING		11/	21/2013
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, 3220 LAKE JOHANNA BOULEV ARDEN HILLS, MN 55112	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 441	hands after remo During an intervie and administrator stated their exper hands between g sanitized in betwee the staff was prov During an intervie on 11/21/13, at 8 expectation was hands in betweer gloves. The Glove Techn 2010, directed str tasks and proced contact with mate concentration of promptly after us non-contaminate surfaces, and be and wash hands microorganisms environments." R11 and R82 had on their beds use On 11/18/13, at a observed R11's k in the up position with black foams ripped off and the the foam. In add was padded with were white patch	wing the gloves during pericare. www.with the director of nursing on 11/21/13, at 8:30 a.m. both ctation of staff was to wash their loves changes or use hand een, depending on what cares		441		

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245424	B. WING_		111	21/2013
	F PROVIDER OR SUPPLIER BYTERIAN HOMES OF	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112		
(X4) IE PREFI TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
F 44	During an interview 8:42 a.m. with the 18:42 a.m. with the 18 the padding on R1 provide a cleanable condition. The mastated, would contagor doing the padding as soon as During an interview 9:25 a.m. RN-G sta	v conducted on 11/21/13, at maintenance director verified 1 and R82's grab bars did not e surface in the current initenance director further act the staff person responsible ng and would replace the spossible. v conducted on 11/21/13, at ated was not aware of the would update maintenance	F 44	41		
		and procedure related to rab bars was requested, t provided.		***************************************		
		• · · ·				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 12/03/2013 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A, BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** 245424 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF ARDEN HILLS

(X3) DATE SURVEY COMPLETED

11/20/2013

3220 LAKE JOHANNA BOULEVARD

ARDEN HILLS, MN 55112							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K 000	INITIAL COMMENTS	K 000					
	Presbyterian Home of Arden Hills is a 4-s building with a full basement. The building constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type II(222) constructed to the side of the building that was determined to Type II(222) construction. Because the original building and the addition are of 2 different construction codes the facility was survey two separate buildings. The building is fully sprinkler protected. The facility has a complete fire alarm system of smoke detection in the corridors and space open to the corridor, that is monitored for automatic fire department notification. The has a licensed capacity of 208 beds and locensus of 204 at the time of the survey. The requirement at 42 CFR Subpart 483. MET.	g was nal s ction. In West to be of riginal t red as he with ces e facility had a					
	Tom Linhoff, Life Safety Code Spc.		12				

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.

F5424023

Printed: 12/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A, BUILDING 02 - 2006 ADDITION

(X3) DATE SURVEY COMPLETED

245424

B. WING

11/20/2013

NAME OF PROVIDER OR SUPPLIER

PRESBYTERIAN HOMES OF ARDEN HILLS

STREET ADDRESS, CITY, STATE, ZIP CODE

3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

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			
	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	TITLE	(XA) DATE			

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.



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 <u>only a suggestion</u> 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.

Presbyterian Homes Of Arden Hills December 9, 2013 Page 2

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

Dore Klegge

Enclosure(s)

cc: Original - Facility

Licensing and Certification File