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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H86M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 23579

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245613**
2.STATE VENDOR OR MEDICAID NO.
(L2) **836967000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF NORTH OAKS**
(L4) **5919 CENTERVILLE ROAD**
(L5) **NORTH OAKS, MN** (L6) **55127**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 12/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Health Program Representative — 12/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/02/2006
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/26/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245613

December 18, 2017

Ms. Alana Nelson, Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

Dear Ms. Nelson:

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 November 14, 2017 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 18, 2017

Ms. Alana Nelson, Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: Project Number S5613014

Dear Ms. Nelson:

On October 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 5, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 30, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 14, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 5, 2017, effective November 14, 2017 and therefore remedies outlined in our letter to you dated October 17, 2017, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 18, 2017

Ms. Alana Nelson, Administrator
Presbyterian Homes of North Oaks
5919 Centerville Road
North Oaks, MN 55127

Re: Reinspection Results - Project Number S5613014

Dear Ms. Nelson:

On November 27, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 5, 2017, with orders received by you on October 17, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H86M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 23579

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(L1) **245613**

2.STATE VENDOR OR MEDICAID NO.
(L2) **836967000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF NORTH OAKS**
(L4) **5919 CENTERVILLE ROAD**
(L5) **NORTH OAKS, MN** (L6) **55127**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/05/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Heim, HPR-Social Work Specialist — 10/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 11/07/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/02/2006
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/08/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 17, 2017

Ms. Alana Nelson, Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: Project Number S5613014

Dear Ms. Nelson:

On October 5, 2017, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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:

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

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

Remedies - 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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 November 14, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 14, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 January 5, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 5, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	10/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On October 2, through October 5th, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 242		11/14/17

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

Electronically Signed | 10/26/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	10/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1 facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide bathing preferences for 1 of 1 resident reviewed for choices, R68. Findings include: R68's most recent Minimum Data Set (MDS), dated 9/7/17, revealed R68 had long term and short term memory problems, impairments with memory and recall and rarely or never made decisions regarding tasks of daily life. R68 required extensive assistance with activities of daily living such as transfers, bed mobility and personal hygiene. Bathing support was not assessed as it was not provided during assessment period. On 10/2/17 at 7:15 p.m., the a family member of R68, (FM)-A, reported being unsure if R68 was getting the preferred number of baths each week. FM-A reported R68 was previously getting two baths a week, one from the facility and one from the hospice provider. When R68 was discharged from hospice, FM-A did not know if R68 was still getting two baths each week. FM-A said it would be nice if R68 still got two weekly baths. On 10/4/17 at 3:52 p.m., FM-A reported not recalling if the facility asked about R68's bathing preferences. FM-A reiterated the preference for R68 to receive 2 baths per week. On 10/4/17 at 3:32 p.m., the nurse manager (RN)-A reported she was not aware if anyone asked R68 or resident's representative about R68's bathing choices. RN-A reported nursing does not ask about bathing preferences.	F 242	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also noted to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency. F242 Resident R68□s representative was contacted to set up a care conference to discuss plan of care, including bathing preferences, upon notification from surveyor. Care conference was held 10/10/17. At this time, the resident□s bathing preferences were discussed and a second spa bath per week was added to the residents plan of care per the representative□s request. Care conference summaries for all current residents have been reviewed for bathing preferences and will be addressed by the	

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	245613	A. BUILDING _____ B. WING _____	10/05/2017

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

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F 242	Continued From page 2 On 10/4/17 at 3:32 p.m., the administrator reported the facility provided residents only one opportunity for bathing each week, unless another one was requested by resident or resident representative. On 10/4/17 at 3:43 p.m., RN-A and the director of nursing (DON) reported they were unable to find documentation R68 or resident representative was asked about bathing preferences or was notified the facility would provide more than one bathing opportunity each week, if requested. RN-A and DON noted preferences should be assessed at admission and quarterly care conferences. On 10/5/17 at 8:59 a.m., DON again confirmed R68's bathing preferences were not assessed and there was no documentation family was informed of the option for more than one bath each week. Body Audits reviewed for past 3 months going back from 10/5/17 revealed the facility bathed R68 on: 9/24/17, 9/17/17, 9/10/17, 8/27/17, 8/13/17, 8/6/17, 7/30/17 and 7/18/17. A care conference summary, dated 7/24/17, revealed no indication R68's preferences were reviewed or assessed. R68 was enrolled in hospice at the time of the care conference. No care conference record was completed after R68 was discharged from hospice. A psychosocial assessment, completed on 9/7/17, revealed preferences were not assessed. The assessment did indicate "Family or significant other involvement in care discussions" was important to R68.	F 242	facility. The facility will review bathing preferences and educate on how to communicate preference changes at the next resident council meeting. The policy related to resident choice was reviewed and is current. All residents will continue to be assessed regarding their preferences per the RAI schedule and with any change in condition. Staff education was started on 10/10/17 and is ongoing as part of new employee orientation and annual training. Audits of bathing preferences will be conducted weekly for four weeks for 10% of residents and monthly thereafter. Results of audits will be reviewed by the QAPI committee to ensure ongoing compliance. Action plans will be created as indicated. The Care Center Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 11/14/17.	

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F 242	Continued From page 3 The Principles of Liberty-Personally Designed Living with Descriptions policy, dated July 2007, directed staff "Choice-Uphold dignity, self-esteem and independence through freedom of choice. Residents and staff are given a range of options that reflect personal preference. Residents have the right to make choices regarding how they accomplish the work they re responsible for in the home. Choices should be made with consideration of organizational and regulatory policies and procedures."	F 242		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to trim and clean fingernails according to the plan of care for 1 of 1 resident reviewed for nail care (R53). Findings include: R53's care plan, last revised 2/1/16, directed staff "Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. On 10/3/17 at 3:40 p.m. R53 was observed with long untrimmed fingernails on both hands. On	F 282	F282 Resident R53 was provided nail care upon notification from surveyor by a nursing assistant as per the care plan. Care plan for nail care for resident R53 was reviewed and determined to be current. All current residents have been reviewed for assistance needs with nail care. The facility will continue to monitor through daily rounds. The policy related to following the care plan was reviewed and is current. All	11/14/17

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F 282	Continued From page 4 10/4/17 from approximately 8:00 a.m. to 9:30 a.m. R53 was observed to eat breakfast independently. On 10/4/17 at 11:01 a.m., R53 was observed with long nails with dark matter under them on both hands. During interview at this time, R53 reported R53 would prefer staff assist R53 to trim R53's nails and the long untrimmed nails bothered R53 a little. On 10/4/17 at 11:46 a.m., the nurse manager (RN)-A verified R53 had long untrimmed nails with dark matter under them. R56 agreed to allow staff to cut them. RN-A reported R53 frequently refused to allow staff to trim R53's nails and one nursing assistant typically trimmed and cleaned R53's nails, NA-A . On 12:04 p.m., NA-A reported he worked in many areas of the facility and had not been able to offer R53 a nail trim and cleaning for at least 3 weeks. NA-A explained he was successful in trimming and cleaning R53's nails because he had a good rapport with R53 and would explain the nail trimming and cleaning process in great detail as he provided care. A review of behavior notes and progress notes for 9/5/17 to 10/5/17 revealed no indication R53 refused cares, or nail care in particular. The Nail Care policy, reviewed 9/2015, directed staff the purpose of nail care was: "1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems."	F 282	residents are provided nail care as part of activities of daily living as per care plan and resident request or indication. All residents will continue to be assessed for assistance with activities of daily living per the RAI schedule and with any change of condition and care plans will be updated accordingly. Staff education was started on 10/10/17 and is ongoing as part of new employee orientation and annual training. Audits of nail care will be conducted weekly for four weeks for 10% of residents and monthly thereafter. Results of audits will be reviewed by the QAPI committee to ensure ongoing compliance. Action plans will be created as indicated. The Clinical Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 11/14/17.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 312		11/14/17

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F 312	Continued From page 5 personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to trim and clean fingernails for 1 of 1 resident reviewed for nail care (R53). Findings include: R53's most recent Minimum Data Set (MDS), dated 7/18/17, revealed R53 had moderate cognitive impairment, required extensive assistance for personal hygiene and supervision for eating. On 10/3/17 at 3:40 p.m. R53 was observed with long untrimmed fingernails on both hands. On 10/4/17 from approximately 8:00 a.m. to 9:30 a.m. R53 was observed to eat breakfast independently. On 10/4/17 at 11:01 a.m., R53 was observed with long nails with dark matter under them on both hands. During interview at this time, R53 reported R53 would prefer staff assist R53 to trim R53's nails and the long untrimmed nails bothered R53 a little. On 10/4/17 at 11:46 a.m., the nurse manager (RN)-A verified R53 had long untrimmed nails with dark matter under them. R56 agreed to allow staff to cut them. RN-A reported R53 frequently refused to allow staff to trim R53's nails and one nursing assistant typically trimmed and cleaned R53's nails, NA-A . On 12:04 p.m., NA-A reported he worked in many areas of the facility and had not been able to offer R53 a nail trim and cleaning for at least 3 weeks. NA-A explained he was successful in trimming R53's nails because he had a good rapport with R53 and would	F 312	F312 Resident R53 was provided nail care upon notification from surveyor by a nursing assistant as per the care plan. Care plan for nail care for resident R53 was reviewed and determined to be current. The policy for nail care was reviewed and is current. All residents are provided nail care as part of activities of daily living as per care plan and resident request or indication. All residents will continue to be assessed for assistance with activities of daily living per the RAI schedule and with any change of condition. Staff education was started on 10/10/17 and is ongoing as part of new employee orientation and annual training. Audits of following the plan of care for nail care will be conducted weekly for four weeks for 10% of residents and monthly thereafter. Results of audits will be reviewed by the QAPI committee to ensure ongoing compliance. Action plans will be created as indicated. The Clinical Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 11/14/17.	

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F 312	Continued From page 6 explain the nail trimming and cleaning process in great detail as he provided care. A review of behavior notes and progress notes for 9/5/17 to 10/5/17 revealed no indication R53 refused cares, or nail care in particular. R53's care plan, last revised 2/1/16, directed staff "Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. The Nail Care policy, reviewed 9/2015, directed staff the purpose of nail care was: "1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems."	F 312		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 334		11/14/17

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F 334	Continued From page 7 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 334		

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F 334	Continued From page 8 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents received requested pneumococcal vaccinations when 3 of 5 residents (R15, R66, R87) reviewed for immunizations had signed consent forms, but had not received the pneumococcal vaccines. Findings include: The Centers for Disease Control (CDC) website recommends vaccination to help prevent pneumococcal disease, which is any type of infection caused by Streptococcus pneumoniae bacteria. There are two kinds of pneumococcal vaccines available in the United States that are recommended depending on a person's age and medical condition: pneumococcal polysaccharide vaccine (PPSV23), and pneumococcal conjugate vaccine (PCV13). The facility's Pneumococcal Vaccination Policy, last modified 5/16, was written to "ensure that each resident is offered the pneumococcal immunization unless the immunizations are medically contraindicated, resident declines or the resident has already been immunized." The procedure highlighted the Advisory Committee on Immunization Practices (ACIP) recommendation that immunocompetent adults aged 65 or greater receive the two vaccines (PPSV23 and PCV13) in a series. Step one of the procedure explained	F 334	F334 Residents R15, R66, and R87 were reviewed for immunization records and provided the pneumococcal vaccination. All residents were reviewed for immunization documentation and those that have requested, have been provided the pneumococcal vaccination unless medically contraindicated or if already immunized. The Pneumococcal Immunization policy was reviewed and is current. All residents will continue to receive education on pneumococcal immunizations and be offered the immunization unless medically contraindicated or if already immunized. Residents will continue to have the right to refuse the immunizations. Staff education was started on 10/10/17 and is ongoing as part of new employee orientation and annual training. Audits of pneumococcal immunizations will be conducted weekly for four weeks for 10% of residents and monthly thereafter. Results of audits will be reviewed by the QAPI committee to ensure ongoing compliance. Action plans	

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F 334	Continued From page 9 "Each resident's pneumococcal immunization status will be determined upon admission or soon afterwards". Review of the admission record revealed R15 admitted to the facility on 9/25/14. Review of the Immunization Report, dated 10/5/17, did not provide evidence that staff gave R15 either of the CDC recommended pneumococcal vaccines, or that R15 received the vaccines historically. Review of a Pneumococcal Vaccination Consent form revealed R15's representative gave verbal consent on 5/18/16 for R15 to receive the vaccine. During interview on 10/5/17, at 1:05 p.m. the director of nursing (DON) explained that R15's representative wanted R15 to receive the vaccine, so staff filled out a vaccine consent form. However, staff filed the form in the paper chart where it was forgotten. The DON confirmed that R15 did not receive a pneumococcal vaccine while in the facility. Review of the admission record revealed R66 admitted to the facility on 9/21/15. Review of the Immunizations tab in the electronic medical record on 10/5/17, revealed R66 historically received a PPSV23 vaccine, but did not provide evidence that staff gave R66 the PCV13 vaccine. Review of a Pneumococcal Vaccination Consent form signed by a resident representative on 9/21/15, revealed the representative believed R66 had already received the pneumococcal vaccination, but was unsure of the date. During interview on 10/5/17, at 1:23 p.m. the DON explained that R66's family thought R66 already received the vaccines, but after looking	F 334	will be created as indicated. The Clinical Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 11/14/17.	

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F 334	Continued From page 10 into the matter, found R66 had only received the PPSV23 vaccine historically. The DON confirmed that R66 had not yet received the PCV13 vaccine. Review of the admission record revealed R87 admitted to the facility on 1/21/16. Review of the Immunizations tab in the electronic medical record on 10/5/17, revealed R87 historically received a "Pneumovax Dose 1" vaccine. The Immunizations tab did not provide evidence that staff gave R87 the second pneumococcal vaccine. A Pneumococcal Vaccination Consent form signed by a resident representative on 12/31/15, requested that staff give R87 the vaccine. During interview on 10/5/17, at 1:23 p.m. the DON confirmed that R87 had not yet received the PCV13 vaccine.	F 334		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 356		11/14/17

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F 356	Continued From page 11 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the current days nurse staffing hours was posted. This had the potential to impact all 60 residents and visitors. Findings include:	F 356	F356 The nurse staffing data posting was immediately updated upon notification of the surveyor to reflect current date, census, and actual hours worked by licensed and unlicensed nursing staff	

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F 356	Continued From page 12 On 10/2/17 at 11: 35 a.m., the Report of Nursing Staff Directly Responsible for Resident Care at the Gables of Waverly Gardens was observed posted in the lobby. Review of the document, revealed it was dated 9/26/17. On 10/2/17 at 11:35 a.m., the administrator confirmed findings.	F 356	directly responsible for resident care by shift. The nurse hours posting policy was reviewed and is current. Staff education was started on 10/10/17 and is ongoing as part of new employee orientation and annual training. Audits of the nurse staffing data posting will be conducted twice weekly for four weeks and twice monthly thereafter. Results of audits will be reviewed by the QAPI committee to ensure ongoing compliance. Action plans will be created as indicated. The Care Center Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 11/14/17.	
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment	F 441		11/14/17

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F 441	Continued From page 13 implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. BUILDING _____ B. WING _____	10/05/2017

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

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F 441	Continued From page 14 under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dust removal, and proper airflow in the laundry room, to assist in the processing and distributing of clean linens to facility residents. This had the potential to affect all 60 residents currently residing in the facility. Findings include: During a tour of the laundry facilities on 10/5/17, beginning at 9:48 a.m., a housekeeper (H)-A explained how the facility processed all linens, including but not limited to bed sheets, towels, and soaker pads (reusable pads that protect a mattress from moisture). A wall-mounted fan was observed blowing air on the clean laundry folding table. There were currently a couple clean linen items on the folding table. The cover of the fan was dusty. H-A explained trying to clean the fan with multiple products, but not being able to get all the dust out. There was another fan on the floor of the dirty laundry sorting room that was blowing air from the dirty room into the clean laundry washing and drying room. H-A confirmed the location of the fan, and explained that staff placed the fan there to cool the laundry room. Additionally, a sprinkler head was observed on	F 441	F441 The dust was cleaned from the sprinkler head and wall-mounted fan and the portable fan was removed from the room upon notification of the surveyor. The infection control and prevention policy was reviewed and is current. Housekeeper H-A was re-educated on infection control practices on 10/5/17. Staff education was started on 10/10/17 and is ongoing as part of new employee orientation and annual training. A weekly cleaning schedule is followed for areas to maintain cleanliness. Audits of infection control in the laundry room will be conducted twice weekly for four weeks and twice monthly thereafter. Results of audits will be reviewed by the QAPI committee to ensure ongoing compliance. Action plans will be created as indicated. The Care Center Administrator is	

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	245613	A. BUILDING _____ B. WING _____	10/05/2017

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PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

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F 441	Continued From page 15 the ceiling, above where the clean, wet laundry comes out of the washing machines. A thick coating of dust hung from the sprinkler head, moving with the breeze from the fans. H-A noticed the dust and wanted to clean it, but was worried that an attempt to clean the sprinkler head would cause damage to the sprinkler. During interview on 10/5/17, at 12:23 p.m., after explaining the location of the fans, the dirty laundry room air blowing into the clean area, and the dust on the fan and sprinkler head, the director of nursing (DON) confirmed that she would look into the issues. When asked for a policy regarding laundry, the DON did not believe the facility had a policy covering the specific problems noted.	F 441	responsible for ongoing compliance. The completion date for certification purposes will be 11/14/17.	

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	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/04/2017**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED As VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Presbyterian Homes of North Oaks was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/26/2017

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

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K 000	Continued From page 1 Or by email to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was surveyed as one building. Presbyterian Homes of North Oaks is on the 1st floor (ground level) of a 3-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 2005 and was determined to be of Type II(111) construction. In 2008 a 3 story addition was constructed to the East and was determined to be of Type II(111) construction. The nursing home uses only the 1st floor and is fire separated from the other floors. The building is fire sprinklered throughout and also has a fire alarm system with smoke detectors in the corridors, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 60 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=D	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.1.3.3. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 14 of 60 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 10/04/2017, observations revealed that the 2	K 133	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also noted to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement	11/14/17

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K 133	Continued From page 3 hour fire rated wall separating the North Gables care center from the Town Center assisted living area multiple penetrations by communication and other wiring that is running through the separation above the ceiling tile above the double doors. This deficient condition was verified by a Maintenance Supervisor.	K 133	of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency. The penetrations in the two hour rated wall separating North Gables and the Town Center area above the ceiling tiles were filled to meet requirements as detailed in the 101 (2012) section 19.1.3.3. The Environmental Services Director will be responsible for ongoing compliance. The date certain for certification purposes is 11/14/2017.	
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting maintained and operational in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect the residents, as well as an undetermined number of staff, and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 10/04/2017, observation revealed that the battery operated emergency light found in the North Gables storage room was inoperative when tested at the time of the inspection.	K 291	The emergency light in the North Gables storage room was replaced and is operational in accordance with NFPA 101 (2012) section 9.9.3. The Environmental Services Director will be responsible for ongoing compliance. The date certain for certification purposes is 11/14/2017.	11/14/17

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K 291	Continued From page 4 This deficient condition was verified by the Maintenance Supervisor.	K 291		
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2012 NFPA 101, "The Life Safety Code" Sections 19.3.4.1 and 9.6, as well as 2010 NFPA 72, "National Fire Alarm and Signaling Code" sections 29.8.3.4. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affect the residents, as well as an undetermined number of staff, and visitors	K 341	A deflector was placed between the smoke detector and the HVAC vent diffuser in the South Gables main laundry room to be in accordance with NFPA 101 (2012) sections 19.3.4.1 and 9.6, as well as NFPA 72 (2010) section 29.8.3.4. The Environmental Services Director will be responsible for ongoing compliance. The date certain for certification purposes is 11/14/2017.	11/14/17

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K 341	Continued From page 5 Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 10/04/2017, observation revealed, that the smoke detector located in the South Gables main laundry room was found to be installed within 36 inches of a HVAC vent diffuser. This deficient condition was verified by the Maintenance Supervisor.	K 341		
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 60 of 60 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 901	The facility Building Utility Risk Assessment documents will be amended to meet requirements as detailed in NFPA 99 (2012) section 4.1. The risk assessment documents will be amended to account for all of the systems that are identified in chapters 10 and 11 of NFPA 99 (2012) including Electrical Equipment (Chapter 10) and Portable Patient Gas Equipment (Chapter 11). The	11/14/17

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K 901	Continued From page 6 On facility tour between 10:00 a.m. to 3:00 p.m. on 10/04/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility has a risk assessment document but upon reviewing the document it was found that the assessment was incomplete. The current risk assessment did not account for all of the systems that are identified in chapters 10 and 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition. This deficient condition was verified by the Maintenance Supervisor.	K 901	Presbyterian Homes Regional Engineering Manager will be responsible to amend the risk assessment documents to meet the code requirements and provide the documents to the facility Environmental Services Director. The Environmental Services Director will be responsible to review the documentation for accuracy as related to this facility and replace the current building utility risk assessment documents in the Life Safety Systems survey documentation folder with the updated documents. The documents will be amended, reviewed and placed in the LSS manual by 11/14/2017.	

Electronically delivered
October 17, 2017

Ms. Alana Nelson, Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

Re: Project Number S5613014

Dear Ms. Nelson:

The above facility was surveyed on October 2, 2017 through October 5, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact at susanne.reuss@state.mn.us or (651) 201-3793.

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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23579	A. BUILDING: _____ B. WING _____	10/05/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/2/17, 10/3/17, 10/4/17 and 10/5/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23579	A. BUILDING: _____ B. WING _____	10/05/2017

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to trim and clean fingernails according to the plan of care for 1 of 1 resident reviewed for nail care (R53). Findings include: R53's care plan, last revised 2/1/16, directed staff "Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. On 10/3/17 at 3:40 p.m. R53 was observed with long untrimmed fingernails on both hands. On 10/4/17 from approximately 8:00 a.m. to 9:30 a.m. R53 was observed to eat breakfast independently. On 10/4/17 at 11:01 a.m., R53 was observed with long nails with dark matter under them on both hands. During interview at this time, R53 reported R53 would prefer staff assist R53 to trim R53's nails and the long	2 565	Corrected.	11/14/17

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2 565	Continued From page 3 untrimmed nails bothered R53 a little. On 10/4/17 at 11:46 a.m., the nurse manager (RN)-A verified R53 had long untrimmed nails with dark matter under them. R56 agreed to allow staff to cut them. RN-A reported R53 frequently refused to allow staff to trim R53's nails and one nursing assistant typically trimmed and cleaned R53's nails, NA-A . On 12:04 p.m., NA-A reported he worked in many areas of the facility and had not been able to offer R53 a nail trim and cleaning for at least 3 weeks. NA-A explained he was successful in trimming and cleaning R53's nails because he had a good rapport with R53 and would explain the nail trimming and cleaning process in great detail as he provided care. A review of behavior notes and progress notes for 9/5/17 to 10/5/17 revealed no indication R53 refused cares, or nail care in particular. The Nail Care policy, reviewed 9/2015, directed staff the purpose of nail care was: "1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems." Based on observation, interview and document review, the facility failed to trim and clean fingernails according to the plan of care for 1 of 1 resident reviewed for nail care (R53). Findings include: R53's care plan, last revised 2/1/16, directed staff "Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes	2 565		

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2 565	Continued From page 4 to the nurse. On 10/3/17 at 3:40 p.m. R53 was observed with long untrimmed fingernails on both hands. On 10/4/17 from approximately 8:00 a.m. to 9:30 a.m. R53 was observed to eat breakfast independently. On 10/4/17 at 11:01 a.m., R53 was observed with long nails with dark matter under them on both hands. During interview at this time, R53 reported R53 would prefer staff assist R53 to trim R53's nails and the long untrimmed nails bothered R53 a little. On 10/4/17 at 11:46 a.m., the nurse manager (RN)-A verified R53 had long untrimmed nails with dark matter under them. R56 agreed to allow staff to cut them. RN-A reported R53 frequently refused to allow staff to trim R53's nails and one nursing assistant typically trimmed and cleaned R53's nails, NA-A . On 12:04 p.m., NA-A reported he worked in many areas of the facility and had not been able to offer R53 a nail trim and cleaning for at least 3 weeks. NA-A explained he was successful in trimming and cleaning R53's nails because he had a good rapport with R53 and would explain the nail trimming and cleaning process in great detail as he provided care. A review of behavior notes and progress notes for 9/5/17 to 10/5/17 revealed no indication R53 refused cares, or nail care in particular. The Nail Care policy, reviewed 9/2015, directed staff the purpose of nail care was: "1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems." SUGGESTED METHOD OF CORRECTION:	2 565		

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2 565	Continued From page 5 The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to trim and clean fingernails for 1 of 1 resident reviewed for nail care (R53). Findings include: R53's most recent Minimum Data Set (MDS), dated 7/18/17, revealed R53 had moderate cognitive impairment, required extensive assistance for personal hygiene and supervision for eating. On 10/3/17 at 3:40 p.m. R53 was observed with	2 860	Corrected.	11/14/17

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2 860	Continued From page 6 long untrimmed fingernails on both hands. On 10/4/17 from approximately 8:00 a.m. to 9:30 a.m. R53 was observed to eat breakfast independently. On 10/4/17 at 11:01 a.m., R53 was observed with long nails with dark matter under them on both hands. During interview at this time, R53 reported R53 would prefer staff assist R53 to trim R53's nails and the long untrimmed nails bothered R53 a little. On 10/4/17 at 11:46 a.m., the nurse manager (RN)-A verified R53 had long untrimmed nails with dark matter under them. R56 agreed to allow staff to cut them. RN-A reported R53 frequently refused to allow staff to trim R53's nails and one nursing assistant typically trimmed and cleaned R53's nails, NA-A . On 12:04 p.m., NA-A reported he worked in many areas of the facility and had not been able to offer R53 a nail trim and cleaning for at least 3 weeks. NA-A explained he was successful in trimming R53's nails because he had a good rapport with R53 and would explain the nail trimming and cleaning process in great detail as he provided care. A review of behavior notes and progress notes for 9/5/17 to 10/5/17 revealed no indication R53 refused cares, or nail care in particular. R53's care plan, last revised 2/1/16, directed staff "Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. The Nail Care policy, reviewed 9/2015, directed staff the purpose of nail care was: "1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems." SUGGESTED METHOD OF CORRECTION:	2 860		

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2 860	Continued From page 7 The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring nail care is provided for each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing nail care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dust removal, and proper airflow in the laundry room, to assist in the processing and distributing of clean linens to facility residents. This had the potential to affect all 60 residents currently residing in the facility. Findings include: During a tour of the laundry facilities on 10/5/17, beginning at 9:48 a.m., a housekeeper (H)-A	21675	Corrected.	11/14/17

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21675	Continued From page 8	21675		

explained how the facility processed all linens, including but not limited to bed sheets, towels, and soaker pads (reusable pads that protect a mattress from moisture). A wall-mounted fan was observed blowing air on the clean laundry folding table. There were currently a couple clean linen items on the folding table. The cover of the fan was dusty. H-A explained trying to clean the fan with multiple products, but not being able to get all the dust out. There was another fan on the floor of the dirty laundry sorting room that was blowing air from the dirty room into the clean laundry washing and drying room. H-A confirmed the location of the fan, and explained that staff placed the fan there to cool the laundry room. Additionally, a sprinkler head was observed on the ceiling, above where the clean, wet laundry comes out of the washing machines. A thick coating of dust hung from the sprinkler head, moving with the breeze from the fans. H-A noticed the dust and wanted to clean it, but was worried that an attempt to clean the sprinkler head would cause damage to the sprinkler.

During interview on 10/5/17, at 12:23 p.m., after explaining the location of the fans, the dirty laundry room air blowing into the clean area, and the dust on the fan and sprinkler head, the director of nursing (DON) confirmed that she would look into the issues. When asked for a policy regarding laundry, the DON did not believe the facility had a policy covering the specific problems noted.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could develop a cleaning protocol for the laundry room. The administrator or designee could ensure staff are trained on the protocol and monitor regularly for

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21675	Continued From page 9 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable	21830		11/14/17

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21830	Continued From page 10	21830		

efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and

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21830	Continued From page 11 the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide bathing preferences for 1 of 1 resident reviewed for choices, R68. Findings include: R68's most recent Minimum Data Set (MDS), dated 9/7/17, revealed R68 had long term and short term memory problems, impairments with memory and recall and rarely or never made decisions regarding tasks of daily life. R68 required extensive assistance with activities of daily living such as transfers, bed mobility and personal hygiene. Bathing support was not assessed as it was not provided during assessment period. On 10/2/17 at 7:15 p.m., the a family member of R68, (FM)-A, reported being unsure if R68 was getting the preferred number of baths each week. FM-A reported R68 was previously getting two baths a week, one from the facility and one from	21830	Corrected.	

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21830	Continued From page 12 the hospice provider. When R68 was discharged from hospice, FM-A did not know if R68 was still getting two baths each week. FM-A said it would be nice if R68 still got two weekly baths. On 10/4/17 at 3:52 p.m., FM-A reported not recalling if the facility asked about R68's bathing preferences. FM-A reiterated the preference for R68 to receive 2 baths per week. On 10/4/17 at 3:32 p.m., the nurse manager (RN)-A reported she was not aware if anyone asked R68 or resident's representative about R68's bathing choices. RN-A reported nursing does not ask about bathing preferences. On 10/4/17 at 3:32 p.m., the administrator reported the facility provided residents only one opportunity for bathing each week, unless another one was requested by resident or resident representative. On 10/4/17 at 3:43 p.m., RN-A and the director of nursing (DON) reported they were unable to find documentation R68 or resident representative was asked about bathing preferences or was notified the facility would provide more than one bathing opportunity each week, if requested. RN-A and DON noted preferences should be assessed at admission and quarterly care conferences. On 10/5/17 at 8:59 a.m., DON again confirmed R68's bathing preferences were not assessed and there was no documentation family was informed of the option for more than one bath each week. Body Audits reviewed for past 3 months going back from 10/5/17 revealed the facility bathed R68 on: 9/24/17, 9/17/17, 9/10/17, 8/27/17, 8/13/17, 8/6/17, 7/30/17 and 7/18/17.	21830		

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21830	Continued From page 13 A care conference summary, dated 7/24/17, revealed no indication R68's preferences were reviewed or assessed. R68 was enrolled in hospice at the time of the care conference. No care conference record was completed after R68 was discharged from hospice. A psychosocial assessment, completed on 9/7/17, revealed preferences were not assessed. The assessment did indicate "Family or significant other involvement in care discussions" was important to R68. The Principles of Liberty-Personally Designed Living with Descriptions policy, dated July 2007, directed staff "Choice-Uphold dignity, self-esteem and independence through freedom of choice. Residents and staff are given a range of options that reflect personal preference. Residents have the right to make choices regarding how they accomplish the work they re responsible for in the home. Choices should be made with consideration of organizational and regulatory policies and procedures." SUGGESTED METHOD OF CORRECTION: The interdisciplinary team could develop a system to assess resident preferences. Staff could be trained in this system. The administrator or designee could audit for compliance in implementing the system and share results with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		