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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ISP2

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 **01/19/2017** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 01/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 02/08/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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 02/09/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/03/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245613
February 8, 2017

Ms. Karen Casper-Robeson, Administrator
Presbyterian Homes of North Oaks
5919 Centerville Road
North Oaks, MN 55127

Dear Ms. Casper-Robeson:

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 January 6, 2017 the above facility is certified for or recommended 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 8, 2017

Ms. Karen Casper-Robeson, Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: Project Number S5613013

Dear Ms. Casper-Robeson:

On December 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 19, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 6, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, effective January 6, 2017 and therefore remedies outlined in our letter to you dated December 16, 2016, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245613 Y1	A. Building B. Wing Y2	1/19/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0314	Correction	ID Prefix F0329	Correction
Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.25(b)(1)	Completed	Reg. # 483.45(d)	Completed
LSC	01/06/2017	LSC	01/06/2017	LSC	01/06/2017
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/06/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 02/08/2017	SIGNATURE OF SURVEYOR 16022	DATE 01/19/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/1/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ISP2

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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 **12/01/2016** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **A1*** (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 :
Momodou Fatty, HFE NE II — 12/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/03/2017 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 01/03/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 16, 2016

Ms. Karen Casper-Robeson, Administrator
Presbyterian Homes of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: Project Number S5613013

Dear Ms. Casper-Robeson:

On December 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (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 January 10, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- 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 March 1, 2017 (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 June 1, 2017 (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 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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 _____	12/01/2016

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 A recertification survey was conducted November 28, 29, 30 and December 1, 2016. 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 ser 12/29/16		
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 follow the care plan for repositioning 1 of 1 resident (R28) reviewed for pressure ulcers. Findings include: R28's care plan, dated 5/11/16, directed staff to reposition R28 every two hours.	F 282	THIS PLAN AND RESPONSE TO THESE SURVEY FINDINGS IS WRITTEN SOLEY TO MAINTAIN CERTIFICATION IN THE MEDICARE PROGRAM. THESE WRITTEN RESPONSES DO NOT SONXTITUTE AN ADMISSION OF NONCOMPLIANCE WIHT ANY REQUIREMENT NOT AGREEMENT WITH ANY FINDINGS.	1/6/17

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

Electronically Signed | 12/23/2016

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 _____	12/01/2016

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 282	Continued From page 1 R28's undated nursing assistant care sheet directed care staff to reposition the resident every two hours during the day and on all rounds at night. During continuous observation on 11/30/16 beginning at 7:10 a.m., R28 was seen sitting in a wheelchair in the kitchenette, listening to music. At 7:19 a.m., registered nurse (RN-A) brought R28 to room to provide treatment to a pressure ulcer on the heel. R28 remained seated in the wheelchair throughout treatment. After treatment, RN-A wheeled R28 back to the kitchenette until it was time to go to breakfast. Staff brought R28 in the wheelchair to the dining room at 8:07 a.m. to eat breakfast until 8:42 a.m., when staff moved R28 to sit in front of the television in the lounge off the dining room. R28 sat in the wheelchair in front of the television until 9:29 a.m. when nursing assistant (NA-B) brought R28 to her room and repositioned R28 during toileting. In an interview on 11/30/16 at 9:52 a.m., when asked whether R28 was repositioned earlier in the day, NA-B said that this was the first time she had contact with R28 today, and that NA-C might know more about repositioning because she got R28 up that morning. In an interview on 11/30/16 at 10:08 a.m., NA-C explained she got R28 up at approximately 6:40 a.m. for morning cares, and then brought R28 to sit in the kitchenette and listen to music with other residents before they went to the dining room for breakfast. In an interview on 11/30/16 at 12:43 p.m., RN-D said that R28 was not ambulatory, and needed to	F 282	WE WISH TO PRESERVE OUR RIGHT TO DISPUTE THESE FINDINGS IN THEIR ENTIRITY AT ANY TIME AND IN ANY LEGAL ACTION. WE MAY SUBMIT A SEPERATE REQUEST FOR INFORMAL DISPUT RESOLUTION FOR CERTAIN FINDINGS AND DETERMINATIONS. F282 Resident #28 care plan and NAR care communication tool was reviewed and updated to reflect current interventions. Staff involved in the care of the resident #28, were re-educated on the importance of following the care plan. NAR-B was re-educated on ensuring all residents' plans of care are followed. All residents' assessments and care plans were reviewed and updated for those who are on a toileting and repositioning program The NAR care communication tool was also updated to reflect intervention. Staff are informed regarding changes in the plan of care at shift stand up meetings and through daily report and in the NAR care communication tool. All resident are assessed on admission, annually, with significant change in condition and reviewed quarterly for care planning and repositioning. Nursing staff was in-serviced on the importance of following residents plan of care at all times. The policy and procedure related to care	

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F 282	Continued From page 2 be repositioned every two hours during the day, and on rounds overnight. When asked if there was a grace period past two hours for repositioning, RN-D shook her head back and forth and replied that R28 should be repositioned every two hours. RN-D explained that staff would need to lay R28 down in bed, or stand R28 up from the wheelchair to relieve pressure.	F 282	planning for each resident has bee reviewed and is current. The Clinical Administrator or designee will audit staff providing direct cares to assure compliance. Random audits of 10% of the residents will be conducted on weekly to determine ongoing compliance. Audit results will be reported to the QA committee and action plans developed as needed. The Clinical Administrator is responsible for ongoing compliance. Date certain for the purpose of ongoing compliance is 1/6/2016	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reduce the risk of	F 314	F314 Resident #28 was reassessed for	1/6/17

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F 314	Continued From page 3 developing a pressure ulcer by repositioning 1 of 1 resident (R28) at risk for pressure ulcers. Findings include: The care area assessment worksheet, dated 7/7/16, described R28 at risk for developing pressure ulcers related to needing extensive assistance with bed mobility and transfers, being non-ambulatory, and a diagnosis of dementia. The quarterly minimum data set assessment, dated 10/2/16, confirmed R28 required extensive assistance in transferring, bed mobility, and toileting. R28's diagnoses included an unstageable pressure ulcer on the sacral region that was acquired during the facility stay. A wound assessment flow sheet revealed the coccyx ulcer was first discovered on 8/14/16, and healed by 9/2/16. R28's care plan, dated 5/11/16, indicated R28 had limited physical mobility related to right sided weakness, dementia, and muscle weakness. Additionally, R28 had the potential for alteration in skin integrity related to weakness, dementia, incontinence, and impaired cognition. The goal listed in the care plan was for R28's skin to remain intact. To meet this goal, the care plan directed staff to reposition R28 every two hours. R28's undated nursing assistant care sheet directed care staff to reposition the resident every two hours during the day and on all rounds at night. During continuous observation on 11/30/16	F 314	repositioning and the assessment and care plan updated as indicated The HAR car communication tool was also reviewed and is current for Resident #28. NAR-B was re-educated on ensuring all residents' plans of care are followed. All resident sere reviewed for repositioning and their care plans updated to reflect current needs. The HAR care communication tool for residents was reviewed and is current. The policy and procedure related skin risk assessment has been reviewed and is current. All residents are assessed on admission, annually, with significant change in condition and reviewed quarterly for care planning and repositioning. Nursing staff was in-serviced on the importance of timely reposition and following care plan. The Clinical Administrator or designee will audit staff providing direct cares to assure compliance. Random audits of 10% of the residents will be conducted weekly to assure ongoing compliance. Audit results will be reported to the QA committee and action plans developed as needed. Date certain for the purposes of ongoing compliance is 01/06/2017 The Clinical Administrator is responsible or ongoing compliance.	

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F 314	Continued From page 4	F 314		

beginning at 7:10 a.m., R28 was seen sitting in a wheelchair in the kitchenette, listening to music. At 7:19 a.m., registered nurse (RN-A) brought R28 to room to provide treatment to a pressure ulcer on the heel. R28 remained seated in the wheelchair throughout treatment. After treatment, RN-A wheeled R28 back to the kitchenette until it was time to go to breakfast. Staff brought R28 in the wheelchair to the dining room at 8:07 a.m. to eat breakfast until 8:42 a.m., when staff moved R28 to sit in front of the television in the lounge off the dining room. R28 sat in the wheelchair in front of the television until 9:29 a.m. when nursing assistant (NA-B) brought R28 to her room and repositioned R28 during toileting.

In an interview on 11/30/16 at 9:52 a.m., when asked whether R28 was repositioned earlier in the day, NA-B said that this was the first time she had contact with R28 today, and that NA-C might know more about repositioning because she got R28 up that morning.

In an interview on 11/30/16 at 10:08 a.m., NA-C explained she got R28 up at approximately 6:40 a.m. for morning cares, and then brought R28 to sit in the kitchenette and listen to music with other residents before they went to the dining room for breakfast.

In an interview on 11/30/16 at 12:43 p.m., RN-D confirmed that R28 was not ambulatory, and had history of an open pressure ulcer on the coccyx. RN-D said R28 was to be repositioned every two hours during the day, and on rounds overnight. When asked if there was a grace period past two hours for repositioning, RN-D shook her head back and forth and replied that R28 should be repositioned every two hours. RN-D said R28 was

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F 314	Continued From page 5 at risk for pressure ulcers, and confirmed that R28 had a greater risk for the coccyx area to re-open because of the previously healed ulcer in that location. In order to fully relieve the pressure from the coccyx, RN-D explained that staff would need to lay R28 down in bed, or stand R28 up from the wheelchair.	F 314		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate monitoring of antipsychotic medications for 1 of 5 residents (R23) who used Seroquel (antipsychotic).	F 329	F329 Resident #23 treatment administration records (TAR) were reviewed and side effect monitoring was added for antipsychotic medication.	1/6/17

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F 329	Continued From page 6 Findings include: On 11/29/16 at 3:50 p.m. R23 was observed to be awake, sitting in her chair. When approached and interviewed regarding the medication, Seroquel, that she takes, R23, stated she did not notice or experience any side effects from the medication but did identify that she likes to stay in her room. During the interview R23 was observed to be relaxed with no behaviors noted. R23 admission record revealed that R23 had diagnoses that included visual hallucinations, Dementia with behavior disturbance, insomnia, Delusional disorders and anxiety. The Physician Orders indicated R23 had an order for Seroquel 25 mg by mouth at bedtime for Hallucinations, which was initiated, dated 9/2/16. The medication administration records for November, 2016, revealed the resident was currently receiving this medication. The treatment administration records (TAR) for November, 2016, read, "Monitoring for side effects for antiepileptic, antianxiety ..." There was no reference to side effects or target behavior monitoring related to Seroquel use on the current TAR. MDS dated 9/12/16 indicated R23 had x 7 days of the antipsychotic medication. R23's care plan dated 9/25/15, identified R23 received an antidepressant and antianxiety medication with sleep monitoring and target behavior. The care plan did not identify Seroquel as an antipsychotic medication and lacked	F 329	Resident #23 care plan was reviewed and updated to reflect resident having scheduled antipsychotic medication and direction for staff to monitor for side effects and target behaviors for psychotic medication use. All residents are reviewed by the pharmacist consultant monthly and all recommendations are acted upon timely per facility policy. All residents are reviewed for unnecessary medications upon admission, annually, quarterly and with significant change in conjunction with the RAI process with care plans updated. All residents TARs have been reviewed for medication side effect monitoring and updated if indicated. Psychoactive medication checklist for initiation of administration and the Psychoactive Medication and Unnecessary Medication Use Policy was reviewed and is current. Nursing staff was in-serviced on the policy and procedure. Audits will be conducted monthly for unnecessary medications and monitoring of side effects. Audits will be conducted monthly on 10% of resident for 4 months with results reviewed at QA committee and action plans developed as needed to determine ongoing compliance. Date certain for the purposes of ongoing compliance is 01/06/2017. The Clinical Administrator is responsible	

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F 329	Continued From page 7 direction for staff to monitor for side effects and target behaviors for psychotic medication use. MRR (Medication regimen reviewed): Progress note dated 11/16/16 at 2:40 p.m. reads, "Medication regimen reviewed. See communication with MD and/or Nursing regarding: discontinue medication and psychotropic monitoring." The recommendation reads, "1. This resident was recently started on Haldol 2 mg tid (three times a day). The 3rd dose is given at bedtime which is the same time as Seroquel 25 mg and Trazodone. Since the resident is now getting Haldol at bedtime, please clarify with Hospice if Seroquel should be discontinued? 2. Please also add antipsychotic side effects to PCC (point click care) for Haldol." However, there were no details of this in R23's medical record as of 11/30/16 at 10:00 a.m. On 11/30/16 at 9:20 a.m. the pharmacy consultant explained that recommendations had been made for the facility to monitor side effects and the recommendation was sent to director of nursing (DON) via email for facility to clarify with hospice. On 11/30/16 at 10:20 a.m. registered nurse (RN)-D stated, she has received the pharmacist recommendation, however, did not follow thru with it yet. On 11/30/16 at 10:25 a.m. the DON verified R23's medical record lacked side effect monitoring and stated, her expectation is that staff follow the pharmacist recommendation within 30 days and monitoring side effects for antipsychotic meds,	F 329	for ongoing compliance	

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F 329	Continued From page 8 should be initiated immediately. Policy and procedure titled PSYCHOACTIVE MEDICATION AND UNNECESSARY MEDICATION USE POLICY with reviewed date 5/2016, indicated, "... 9. Designated facility staff will monitor for side effects, reduce dosage to the minimum requires and, when possible, discontinue the use of such medications when medically and pharmacologically appropriate..."	F 329		
F 441 SS=D	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 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;	F 441		1/6/17

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F 441	Continued From page 9 (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 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:	F 441		

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F 441	Continued From page 10 Based on observation, interview, and document review, the facility failed to follow infection control guidelines for 1 of 1 resident (R28) observed for wound care, failed to ensure staff used appropriate hand hygiene for 1 of 2 residents (R28) after toileting and failed to ensure infection control practices were followed for 1 of 1 resident (R112) observed for blood sugar testing. Findings include: On 11/30/16 at 7:19 a.m., registered nurse (RN-A) provided wound care to a pressure ulcer on R28's heel. RN-A sat on the carpeted floor in R28's room, with the unopened skin prep, and bottle of lotion sitting directly on the floor beside her. When asked if staff ever used a barrier, such as a towel, to avoid placing wound care supplies directly on the floor, RN-A said she had not used a barrier in the past. In an interview on 11/30/16 at 12:43 p.m., RN-D said that staff should not put anything on the floor when performing wound care. Page six of the Pressure Ulcer/Injury Policy and Procedure, last modified May 2016, described the procedure for dressing change. The procedure directed staff to "Use disposable cloth (paper towel is adequate) to establish clean field on resident's over the bed table. Place all items to be used during procedure on the clean field." On 11/30/16 at 9:29 a.m., nursing assistant (NA-B) brought R28 to the bathroom per the toileting schedule in the resident's care plan. NA-B used the assistance of a mechanical lift to transfer R28 from the wheelchair to the toilet, and	F 441	F441 Staff involved in the care of Resident #28 and Resident #112 were reeducated on infection control guidelines including during wound care, hand hygiene and during blood glucose testing. All staff are educated on infection control practices upon hire, annually and as needed. The policy and procedure related to proper hand washing and glove use, proper placement of medical and wound care supplies in resident rooms have been reviewed and are current. Nursing staff was in-serviced on proper hand washing and glove use, proper disposal of wound care supplies and proper placement of medical equipment in a resident's room. The Clinical Administrator or designee will audit for infection control compliance. Random audits will be conducted of resident care and services weekly regarding infection control practices . Audits results will be reported to the QA committee and action plans developed as needed to ensure ongoing compliance. Date certain for the purposes of ongoing compliance is 01/06/2017 THe Clinical Administrator is responsible for ongoing compliance.	

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back again. When R28 was finished, NA-B, while wearing clean gloves, stood R28 up from the toilet using the lift, wiped the resident, and applied a fresh brief. With the same gloves, NA-B pulled the lift away from the toilet and readjusted the closure on each side of the briefs, and pulled up R28's pants. NA-B flushed the toilet and then disposed of the gloves. Before performing hand hygiene, NA-B adjusted R28's pants, moved the lift out of the bathroom, and lowered the resident into the wheelchair. NA-B adjusted the resident's clothes and placed the resident's feet back on the wheelchair foot pedals. NA-B opened the resident's door and wheeled R28 out of the room into the hallway to wait while NA-B came back into the room to wipe down the handles of the lift with a wipe from inside a bag that was hanging off the lift handle. NA-B moved the lift out of the room, and then came back in the room to collect and tie off the garbage bag from the bathroom waste basket. With the garbage bag in one hand, NA-B opened up the window shades before exiting the room with the waste. NA-B simultaneously carried the waste and wheeled R28 out to the kitchenette. After bringing R28 to the kitchenette, NA-B disposed of the waste, and then washed hands in the kitchenette.

In an interview on 11/30/16 at 12:43 p.m., RN-D said in general, staff should use the sanitizing hand foam on the way into and out of a resident's room, perform hand hygiene when removing gloves, wash hands if going from dirty to clean cares, and if cares involved body fluids. RN-D clarified that for toileting and dealing with waste, staff needed to wash their hands.

The undated Infection Control Standard Precautions Hand Hygiene policy provided by the

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facility directed staff to perform hand hygiene after touching body fluids and excretions; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or the environment. Specific examples included but were not limited to: Before and after assisting a resident with toileting, after contact with a resident's mucous membranes and body fluids or excretions, and after removing gloves.

R112's face sheet indicated R112's diagnoses included type 2 diabetes mellitus (a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood). R112's current order summary report dated 12/1/16, indicated R112 received "accu check before meals and at bedtime."

During observation on 11/30/16, at 7:53 a.m. registered nurse (RN)-C knocked on R112's door, entered room, washed hands and applied gloves. R112 was seated in wheelchair at bathroom sink shaving. RN-C placed glucometer supply bucket on carpeted floor outside bathroom door. RN-C alcohol wiped R112's finger, poked finger with lancette (a sharp pointed medical instrument), obtained sample and glucose result. RN-C threw gloves in garbage, and washed hands. RN-C applied clean gloves, alcohol wiped R112's abdomen, administered insulin injection, removed gloves, threw in garbage, washed hands and left room. RN-C wiped glucometer with purple sani-wipes for one to two minutes and left sani-wipe wrapped around glucometer.

On 11/30/16, at 7:59 a.m. when asked about placement of the glucometer supply bucket,

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 _____	12/01/2016

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 441	Continued From page 13 RN-C stated she felt the floor gets vaccumed so it was accceptable to place bucket down on floor. RN-C indicated she felt the rolling table nearby was clean with R112's personal items on it and did not want to the set bucket on the table. RN-C indicated she felt the bottom of bucket was dirty similar to bottom of a purse so did not want to set it on the table. On 11/30/16, at 11:12 a.m. director of nursing (DON) stated she did not want staff to place glucometer bucket on the floor. DON further indicated it should be placed on the bedside table or tray table. "That is where it should be placed." On 11/30/16, at 2:34 p.m. nurse consultant (NC) stated facility did not have a policy regarding not setting glucometer bucket on the floor. NC further stated "that is something you just should not do."	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 **01 - NURSING HOME** B. WING _____	**12/06/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 06, 2016. At the time of this survey, Presbyterian Homes of North Oaks was found 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) 101 Life Safety Code, Chapter 19 Existing Health Care Occupancies. 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. The nursing home uses only the 1st floor and is fire separated from the other floors. The building is fire sprinklered throughout. The facility 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 building is existing and surveyed as one building. The building has a capacity of 60 beds and had a census of 57 beds at the time of survey.	K 000		

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

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