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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KDHD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/18/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245424

January 27, 2015

Ms. Heather Heijerman, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, Minnesota 55112

Dear Ms. Heijerman:

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 13, 2015 the above facility is certified for:

208 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 22, 2015

Ms. Heather Heijerman, Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, Minnesota 55112

RE: Project Number S5424024

Dear Ms. Heijerman:

On December 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2014. 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 January 18, 2015, 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 5, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2014, effective January 13, 2015 and therefore remedies outlined in our letter to you dated December 23, 2014, 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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245424	A. Building B. Wing	1/18/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **01/13/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **01/13/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/13/2015**
ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **01/13/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/KFD	01/22/2014	10160	01/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/5/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KDHD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Josephine Hassinger, HFE NE II 01/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/21/2015 (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 :
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22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: December 23, 2014

Ms. Heather Heijerman, Administrator
Presbyterian Homes of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, Minnesota 55112

RE: Project Number S5424024

Dear Ms. Heijerman:

On December 5, 2014, 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 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 14, 2015, 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 January 14, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 March 5, 2015 (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 5, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	12/05/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		1/13/15

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

Electronically Signed | 01/02/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	12/05/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure confidentiality of medical information was promoted for 1 of 1 resident (R205) who had confidential information visible to other residents, staff, and visitors view. Findings include: The principal diagnoses from the care plan provided by the facility on 12/03/14 included: malignant neoplasm of breast, malignant neoplasm of bone and bone marrow, dysthymic disorder, chronic low back pain, and history of compression fractures. R205's quarterly Minimum Data Set (MDS) dated 11/5/2014 indicated Brief Interview for Mental Status (BIMS) was nine out of a possible score of 15, indicating moderate cognitive impairment. R205's room was observed on 12/01/14 at 8:31 p.m. to have two signs posted on her wall behind her bed and one sign on the wall opposite her bed with the following information displayed: Attention a.m.: Please ask if wants to get up for breakfast or wants a room tray set up at about 8:00-8:30 a.m. During the day, ask if wants to be up in the chair or back in bed. No blood pressure on both arms. This is a new plan: Please read me. Morning medication plan (effective 10/9/2013) meal times need to be considered for several of her meds. A plan has been made with (R205) and family to try	F 164	F164 R205□s use of posting signs in resident□s room reviewed with resident and her responsible party. Postings have been removed and 3 ring-binders provided for resident□s notes and reminders. Resident rooms and households at Care Center were checked for posted notes to ensure resident privacy is maintained. Privacy Practices reviewed and is current. Education on resident privacy initiated and ongoing. Random audits initiated and will be completed on 10% on resident privacy accuracy weekly for four weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Clinical Administrator or designee will be responsible for ongoing compliance. Date for ongoing compliance is January 13, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	12/05/2014

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

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F 164	Continued From page 2 to meet these meal consideration. 9-9:30 a.m. Protonix to be given 30 minutes prior to meal. 9:30-10:00 a.m. breakfast served there is a note in POC (electronic charting system). Offer to help aid with delivery. Give other a.m. meds with breakfast except Lapatinib. 10:30 a.m. Give Zofran 30 minutes before Lapatinib. 11-11:30 a.m. give Lapatinib (goal: give this med hour after breakfast and an hour before lunch) 1:00 p.m. lunch served at 1:00 p.m. there is a note in POC. This information was visible to anyone entering R205's room and some was visible from hallway. On 12/03/14, 1:50 p.m., Licensed Social worker (LSW)-A verified that confidential medical information regarding R295 ' s schedules and daily routines should not be posted on the resident's walls for unauthorized staff or visitors to view.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility did not promote dignity by providing incontinence supplies timely for 1 of 1 resident (R241) who had history of having bladder incontinence and used pull-ups for bladder incontinence management. Findings include:	F 241	F241 Upon notification incontinence product brought to household for R241. Review of Incontinence supply stocking procedure initiated. Par levels are being reviewed and adjusted for her room. Education on supply stocking initiated and ongoing. Random audits will be completed on 10%	1/13/15

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F 241	Continued From page 3 R241 had requested from facility staff the need for more pull-ups and incontinence brief before 5:24 p.m. However, the facility did not pursue acquiring the incontinence pull-ups until the administrator was contacted by surveyors of the need for R241 which was two hours later. During the extended wait time R241 had soiled herself with urine and felt horrible. R241 was observed on 12/1/14 at 5:25 p.m. sitting in a recliner. R241 stated that she did not have any pull-ups (type of incontinent pad) available and had told facility staff that she needed some as soon as possible because she is incontinent of urine. On 12/1/14 at 6:42 p.m. R241 was again observed sitting in her chair in her room and at this time R241 stated she was sitting in wet (urine) pants and stated that she felt horrible. R241 stated she had been asking for more pull-ups since 5:00 p.m. R241's room had a strong urine smell. At 7:10 p.m. R241 was asked if she had received the incontinence pads and she responded by saying no. This surveyor immediately contacted the administrator with the request for more incontinence products for R241 at 7:15 p.m. and the administrator said she would take care of it. The next day 12/2/14 at 8:30 a.m. it was learned from the administrator that R241 had received incontinent products after the surveyors left the building (after 8:00 p.m.) the evening before. The administrator also said that they had to get incontinence pads from the store. The administrator said that R241 had increased incontinence and needed an updated reassessment completed. R241 was admitted to the facility with diagnoses that included diabetes, back pain, and chronic obstructive pulmonary disease. The bladder	F 241	of residents weekly for four weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Clinical Administrator and/or designee will be responsible for ongoing compliance. Date certain for ongoing compliance is January 13, 2015.	

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F 241	Continued From page 4 assessment dated 11/22/14 indicated R241 was alert and oriented and able to communicate her needs to the staff. The bladder assessment indicated R241 was able to take herself to the bathroom but required staff assistance with changing of the pull-up products and providing personal hygiene. The care plan dated 11/18/14 indicated R241 was to receive medium sized pull ups. On 12/4/14 at 8:52 a.m. Registered nurse (RN)-E household coordinator stated staff was still getting to know the resident's routine and have now provided additional pull-ups for her use.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		1/13/15

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F 280	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise a care plan to include oral care as recommended by the dental hygienist for 1 of 3 residents (R146) reviewed for dental care. Findings included: R146's diagnosis from the care plan provided by the facility on 12/03/14 included cerebrovascular disease, abnormal posture, difficulty walking, generalized muscle weakness, dysphagia (difficulty with swallowing), flaccid hemiplegia affecting unspecified side (weakness of the entire left or right side of the body), senile dementia, and pre-senile dementia with delusional features. R146's Brief Interview for Mental Status (BIMS) dated 9/17/2014, were three out of possible fifteen indicating severe cognitive impairment. R146's Annual Minimum Data Set (MDS) dated 9/17/2014 indicated resident required extensive assist of one staff member to perform personal hygiene. The medical record indicated R146 had a dental exam by a registered dental hygienist (RDH) on 9/15/2014 at Apple Tree Dental. The RDH made daily care plan recommendations to maintain oral health that included, "resident needed direct staff assistance, tooth brushing each morning and evening, brush teeth and gums for approximately 2 minutes, as tolerated, using a soft toothbrush and fluoride toothpaste, and the use of a power or electric toothbrush."	F 280	F 280 R146 representative was contacted to consider the dental hygienist recommendations regarding the use of an electric toothbrush on 12/4/14. R146 representative declined the recommendation and this conversation was documented in the medical record. All resident□s care plans reviewed for special oral care instructions recommendations and addressed appropriately. A review of all care plans and My Best Day and/or Point Click Care initiated to ensure accurate and consistent communication regarding special instructions for oral care. The Care Plan Policy including oral hygiene was reviewed and is current. Education initiated 12/23/14 and ongoing. Random audits will be completed on 10% of residents weekly for four weeks. Results will be reported to the QA committee. Action plans will be developed as needed. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for purposes of the ongoing compliance is January 13, 2015.	

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F 280	Continued From page 6	F 280		

R146's care plan dated 9/16/2014 read, " Oral care: I [R146] require cueing with short, simple instruction and physical assistance with mouth care." The care plan lacked the recommendations of the oral care plan as outline by the RDH on 9/15/2014.

R146's Point of Care (electronic record charting system that communicated information about the resident to direct care providers) tasks last updated on 11/25/2013 read, "Please give me mouthwash to rinse my mouth after I brush my teeth in the a.m. and at hs (before bedtime), and oral care assist of 1." The Point of Care tasks lacked the recommendations of oral care plan as outlined by the RDH on 9/15/2014.

R146's "my best days" (a flow sheet that communicated information about the resident to direct care providers) read, "oral care is set up, resident has missing teeth, and has dentures but prefers not to wear them." This flow sheet lacked the recommendations of the oral care plan as outlined by the RDH on 9/15/2014.

During an interview on 12/3/14, at 8:30 a.m. licensed practical nurse (LPN)-A confirmed R146 had missing teeth, chose not to wear dentures, and had a recent dental visit. LPN-A stated she thought the information regarding oral care from RDH was on "my best days" and the care plan.

During an interview on 12/4/14, at 7:57 a.m., nursing assistant (NA)-A stated R146 brushed their own teeth after set up by staff and R146 used a regular tooth brush provided by the facility. NA-A stated R146 did not have a power or electric tooth brush and was not aware if R146's teeth were brushed in the evening. NA-A stated

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F 280	Continued From page 7 special care or equipment instructions could be located on "my best days" or on the computer. During an interview on 12/04/14, at 8:02 a.m. registered nurse (RN)-G stated special oral care instructions and equipment should be indicated on "my best days" for direct care staff to follow.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the plan of care to provide necessary grooming services (nail care) for 1 of 3 residents (R146) reviewed for activities of daily living. Findings included: R146's care plan included the following: "resident has cognitive function/dementia or impaired thought process related to cerebrovascular accident (stroke), left sided weakness, contractures (left upper extremity), potential for alteration in skin integrity related to decreased mobility, history of eye irritation related to history of blepharitis (inflammation of the eyelids), require assistance with personal cares such as dressing and grooming, bathing: check nail length and trim and clean on bath day and as necessary, and require one staff participation with personal	F 282	F282 R146 was assisted with cleansing and trimming of nails immediately when this was brought to staff attention. The residents care plan and My Best Day/POC reviewed and updated for activities of daily living (ADL□s) including nail care. Resident expressed the preference to continue to be offered scheduled nail care on bath days per current plan of care. A review of all resident care plans and bath communication has been initiated to ensure communication is clear regarding nail care. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon a significant change in status. The policy for care plans was reviewed	1/13/15

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F 282	Continued From page 8 hygiene." R146's "my best days" (a flow sheet that communicated information about the resident to direct care providers) indicated bath days were on Wednesday evenings. This flow sheet did not address how nail care was provided, how often, or by who nail care should be provided. On 12/03/14 during lunch time at 12:49 p.m. observation of R146's right hand showed jagged long finger nails. The thumb and index fingernails had black contents underneath the nails. Resident used right hand to eat his meal. R146's left hand also showed long jagged fingernails. R146 ' s principal diagnosis from the care plan (each entry has own date) provided by the facility on 12/03/14 included cerebrovascular disease, abnormal posture, difficulty walking, generalized muscle weakness, dysphagia (difficulty with swallowing), flaccid hemiplegia affecting unspecified side (weakness of the entire left or right side of the body), senile dementia, and pre-senile dementia with delusional features. R146's annual Minimum Data Set (MDS) dated 9/17/2014 indicated resident required extensive assist of one staff member to perform personal hygiene also Brief Interview for Mental Status (BIMS) dated 9/17/2014, was three out of possible fifteen indicating severe cognitive impairment. During an interview on 12/02/14 at 2:02 p.m. a family member (F)-A stated, "Once in a while fingers nails are dirty and we have to tell staff." During an interview on 12/03/14, at 1:10 p.m. registered nurse (RN)-G stated their expectation is nail care is done as needed in the morning and with baths.	F 282	and is current. A review of the procedure for communicating nail cares initiated. Education regarding nail care initiated and ongoing. Random audits will be completed on 10% of residents assuring the care plan and the POC are consistent and assessing the cleanliness of their finger nails for four weeks. Results will be reported to the QA committee. Action plans will be developed as needed. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for purposes of the ongoing compliance is January 13, 2015.	

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F 312	Continued From page 9	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide fingernail grooming and care for 1 of 3 residents (R146) who was assessed to need assistance to meet activities of daily living (ADLs.) Findings included: R146 ' s principal diagnoses from the care plan provided by the facility on 12/03/14 included cerebrovascular disease, abnormal posture, difficulty walking, generalized muscle weakness, dysphagia (difficulty with swallowing), flaccid hemiplegia affecting unspecified side (weakness of the entire left or right side of the body), senile dementia, and pre-senile dementia with delusional features. On 12/03/14 during lunch time at 12:49 p.m. observation of R146's right hand showed jagged long finger nails. The thumb and index fingernails had black contents underneath the nails. Resident used right hand to eat his meal. R146's left hand also showed long jagged fingernails. R146's Minimum Data Set (MDS) dated 9/17/2014 indicated resident required extensive assist of one staff member to perform personal hygiene and the Brief Interview for Mental Status	F 312	F312 R146 was assisted with cleansing and trimming of nails immediately when this was brought to staff attention. The residents care plan and My Best Day/POC was reviewed and updated for activities of daily living (ADL□s) including nail care. Resident expressed the preference to continue to be offered scheduled nail care on bath days per current plan of care. A review of all resident care plans and bath communication has been initiated to ensure communication is clear regarding nail care. A review of the procedure for communicating nail cares initiated. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon a significant change in status to ensure appropriate ADL assistance is provided. The policy for care plans was reviewed and is current. Education regarding nail care initiated and ongoing. Random audits will be completed on 10% of residents assuring the care plan and	1/13/15

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F 312	Continued From page 10 (BIMS) dated 9/17/2014, was three out of possible fifteen indicating severe cognitive impairment.. R146's care plan included the following: "resident has cognitive function/dementia or impaired thought process related to cerebrovascular accident (stroke), left sided weakness, contractures (left upper extremity), potential for alteration in skin integrity related to decreased mobility, history of eye irritation related to history of blepharitis (inflammation of the eyelids), require assistance with personal cares such as dressing and grooming, bathing: check nail length and trim and clean on bath day and as necessary, and require one staff participation with personal hygiene." R146's Point of Care tasks (electronic medical charting system that communicated information about the resident to direct care providers) did not address how nail care was provided, how often, or by who nail care should be provided. R146's "my best days" (a flow sheet that communicated information about the resident to direct care providers) indicated bath days were on Wednesday evenings. This flow sheet did not address how nail care was provided, how often, or by who nail care should be provided. During an interview on 12/02/14, at 2:02 p.m. a family member (F)-A stated, " Once in a while fingers nails are dirty and we have to tell staff." During an interview on 12/03/14, at 1:10 p.m. registered nurse (RN)-G stated their expectation is nail care is done in the morning and with baths as needed.	F 312	the POC are consistent and assessing the cleanliness of their finger nails for four weeks. Results will be reported to the QA committee. Action plans will be developed as needed. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for purposes of the ongoing compliance is January 13, 2014.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332		1/13/15

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F 332	Continued From page 11 medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of less than 5% for 4 of 7 residents (R244, R232, R11, and R199) observed during the medication administration observation. The facility had a medication error rate of 14.29% for 35 medications observed. Findings include: R244 was observed during medication administration on 12/3/14, at 9:01 a.m., medication assistant (MA)-A prepared medications for R244 and placed one tab of glipizide (an anti-diabetic drug) 5 mg (milligrams) into a medication cup (which contained R244's other oral medications.) MA-A then administered the medications to R244 who had been sitting in the dining room eating breakfast. Document review of R244's physician orders dated 11/19/14, identified order for glipizide 5 mg one tablet orally daily before breakfast. R244's medication administration record dated November/December 2014, identified glipizide 5 mg one tablet orally daily before breakfast. MA-A had not administered glipizide before breakfast as per physician orders read. MA-A verified at the time of medication administration glipizide had been given with breakfast. R232 was observed during medication administration on 12/3/14, at 8:46 a.m., MA-D	F 332	F332 Staff Members (TMAs) involved in medication administration for R244, R232, R11, and R199 were re-educated. Education on med pass guidelines for nurses/TMAs initiated and ongoing. Policies regarding med pass were reviewed and is current. Medication pass audits initiated randomly on 10% of resident weekly for 4 weeks. The facility QA&A committee will review the audits and determine the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is January 13, 2015.	

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F 332	Continued From page 12	F 332		

prepared medications for R232 and had placed one tab of levothyroxine (a synthetic thyroid hormone medication) 112 mcg (micrograms) into a medication cup (which contained R232's other oral medications.) MA-D then administered the medications to R232 who had been sitting in the dining room eating breakfast.

Document review of R232's physician orders dated 11/17/14, identified order for levothyroxine 112 mcg one tablet orally daily 30 minutes before food. R232's medication administration record dated November/December 2014, identified levothyroxine 112 mcg one tablet orally daily 30 minutes before food. MA-D had not administered levothyroxine 30 minutes before food as per physician orders read. MA-D verified at the time of medication administration levothyroxine had been given with breakfast.

R11 was observed during medication administration on 12/3/14, at 9:46 a.m., MA-C prepared medications for R11 and had placed potassium chloride solution (an oral potassium supplement) 10 percent 22.5 ml (milliliters) into a plastic medication cup MA-C then administered the medication to R11, who drank the potassium chloride solution medication straight from the plastic medication cup.

Document review of R11's physician orders dated 11/17/14, identified order for potassium chloride solution 10 percent 22.5 ml (30 mEq (millequivalent) orally daily after a meal, mix in fluid. R11's medication administration record dated November/December 2014, identified potassium chloride solution 10 percent 22.5 ml (30 mEq) orally daily after a meal, mix in fluid. MA-C had not administered the potassium

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F 332	Continued From page 13 chloride solution mixed in fluid as per physician orders read. At 10:26 a.m., MA-C verified had not mixed potassium chloride solution in fluid when administered and R11's physician orders read to mix the potassium chloride solution in fluid. R199 was observed during medication administration on 12/3/14, at 9:18 a.m., MA-B prepared medications for R199 and had administered one puff of flovent inhaler (a corticosteroid medication), waited 5 seconds and administered the second puff to R199. MA-B then placed one vial of ipratropium albuterol solution (DuoNeb) (a combination of two medicines called bronchodilators) into a plastic nebulizer medication cup, MA-B had attached the mask to the medication cup, placed the mask on R199 and started the nebulizer machine to administer the medication by inhalation. MA-B had stated to R199 it has been 10 minutes we are done and shut off the nebulizer machine and removed the mask from R199. Surveyor asked to see the nebulizer medication cup and verified with MA-B at the time medication remained in the cup (visible liquid remained in bottom of nebulizer medication cup). During interview at the time MA-B had stated in regards to medication remaining in the nebulizer cup, I thought when it makes the weird sound and give at least 10 minutes then know had most of medication and was done. MA-B verified had only waited five seconds between puffs (had not waited at least one minute between puffs) for the flovent inhaler and had stated if the same inhaler it is o.k. to give one puff right after another, if different medication have to wait five minutes at least. Document review of R199's physician orders dated 11/20/14, identified orders for flovent 220	F 332		

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F 332	Continued From page 14 mcg (micrograms) inhale 2 puffs orally two times daily and DuoNeb inhale one vial per nebulizer two times daily. R199's medication administration record dated November/December 2014, identified flovent 220 mcg (micrograms) inhale 2 puffs orally two times daily and DuoNeb inhale one vial per nebulizer two times daily. During interview on 12/3/14, at 1:58 p.m., registered nurse (RN)-E clinical administrator had stated would expect physician orders to be followed regarding medication administration for R244, R232 and R11. In regards to flovent and DuoNeb medications for R199 RN-E had stated would expect entire dose of DuoNeb to be delivered and wait one minute between puffs for inhaler. Document review of the facility MEDICATION ADMINISTRATION policy dated modified 4/14, read, " PROCEDURE: A. Medication Administration 1. RN'S, LPN's [licensed practical nurses], TMA's [trained medication aides] will administer medications as ordered by the attending Physician/NP [nurse practitioner]." Document review of the facility NEBULIZED INHALATION SOLUTION ADMINISTRATION dated revised 10/22/13, read, "In order to ensure safe and effective delivery of inhalation solutions via nebulizer, follow the procedure below: 10. The treatment is complete when all of the medication is gone, or there is no more mist coming out (average treatment length is 8 to 10 minutes). The nebulizer will also make a sputtering noise when the treatment is done."	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		1/13/15

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F 371	Continued From page 15 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe storage of prepared and refrigerated foods and failed to store clean dishes under sanitary conditions. This had the potential to affect 207 out of 207 residents who receive food prepared from the kitchen. Findings include: During initial kitchen tour on 12/1/14, at 2:43 p.m. the following was observed: refrigerator 1 contained prepared salads, shredded cheese, and crème puffs that were not dated. Opened whipped cream topping bag with no date and not appropriately capped. This refrigerator also contained prune juice dated 11/19/14. Certified Dietary Manager (CDM)-F confirmed prune juice was out dated and should have been disposed of. CDM-F explained foods in this cooler were used the same day and that is why some foods were not dated. The walk in cooler contained chicken base that was partially covered with foil that left contents exposed. Cooler also contained multiple bags of thawed whipped topping (dairy product) with no open date or shelf life after thawing. CDM-F	F 371	F 371 Undated and unlabeled food items were removed and thrown away on 12/1/14. Pans removed and sheet pans rewashed 12/1/14. Standing water cleaned 12/1/14. Policy and procedure has been reviewed, updated and is current. Education for staff initiated on 12/28/14 and is ongoing. Random audits will be completed three times weekly for four weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. New task monitoring system developed to ensure sanitary conditions are met. The Nutrition and Culinary Director will be responsible for ongoing compliance. Date certain for ongoing compliance is January 13, 2015	

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F 371	Continued From page 16 confirmed the uncovered chicken base should have been removed. Facility policy entitled Store, prepare, distribute and serve food under sanitary conditions with a revision date of 12/29/2010 read, "All food items will be dated after opening and used by the use by date, all individual serve items will be used by the use by date on the container and if not used by that date it will be discarded, and All persons that stock refrigerators and kitchenettes and the staff that work in these areas should be checking daily to make sure that all items are dated properly and discarded if not used in the proper allotted time frame." Manufacturer product information guide for " On Top Whipped Topping " indicated frozen shelf life of 365 days and shelf life of 2 weeks refrigerated unopened. Further observation revealed six total Teflon coated pans showed substantial amounts of flaking Teflon. CDM-F confirmed pans were flaking and explained they are replaced periodically and should be replaced now. An uncovered dry dish rack contained a stack of sheet pans; three of five sheet pans were wet with varying amounts of water. CDM-F verified pans were wet and they should not have been put away. Facility guidelines entitled AM Kitchen Dish 2 read, " be sure that when putting any pans, dishes, utensils away that they are completely dry before doing so." Soiled standing water puddles were noted to be in the dishwasher area under and around floor mats and the water had included the food preparation areas adjacent to the dishwasher area. The drain in the dishwasher area was not functions properly and water was backing up. CDM-F verified standing water and explained they had no slip	F 371		

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F 371	Continued From page 17 mats in place to promote safety for staff nor was the drain checked to determine why it was not working. CDM-F stated they were not sure why there was so much water.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		1/13/15

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F 431	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure safe storage of medications for 1 out of 5 medication refrigerators and failed to ensure 2 of 18 medication carts were free of expired medications. Findings include: Lack of monitoring of refrigerator temperatures for storage of medications: During tour of two north medication storage rooms on 12/3/14, at 10:43 a.m., with registered nurse (RN)-A the medication refrigerator temperature had been observed at 49 degrees Fahrenheit. The following medications requiring storage at a certain temperature had been noted to be in the medication refrigerator: one bottle of lorazepam concentrate and one the box read store at 36 to 46 degrees Fahrenheit, one unopened vial of Humalog insulin, one unopened vial of Humulin insulin and three unopened vials of Lantus insulin. Document review of the temperature logs for the medication refrigerator located on two north revealed from 2/14 through 12/2/14 temperatures had been recorded to be as high as 48 degrees Fahrenheit every month from 2/14 except in the month of 10/14 of which 12 days there had been no documentation of recorded temperature. Document review of manufacturer instructions for	F 431	F431 The refrigerator identified on 12/3/14 was taken out of service and replaced immediately. All multi-dose medication vials stored in this refrigerator were taken out of use and replaced by a new supply ordered from pharmacy. The expired medications identified on the medication cart were removed immediately. Policy and procedure for medication storage was reviewed and is current. Education on refrigerator monitoring initiated and ongoing. Weekly Audits of medication administration and storage including review of the Refrigerator Temp Logs initiated weekly for four weeks and with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing and action plans. The Clinical Administrator is responsible for ongoing compliance. Date certain for ongoing compliance is January 13, 2015.	

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storage provided by the facility identified the following: lorazepam concentrate store at cold temperature-refrigerate 36-46 degrees Fahrenheit, Humalog unopened should be stored in a refrigerator 36-46 degrees Fahrenheit, Humulin vials not in use should be stored in a refrigerator 36-46 degrees Fahrenheit and Lantus unopened vials should be stored in a refrigerator 36-46 degrees Fahrenheit.

During interview on 12/4/14, at 11:10 a.m., consultant pharmacist (CP)-D had stated the varying refrigerator temps up to 48 degrees for insulins and injectable Ativan would be a judgment call not knowing how long the refrigerator was out of the recommended temperature range. CP-D had stated would expect that the medications would have been replaced because you would not know how long they would have been out of the recommended range.

During interview on 12/3/14, at 1:58 p.m., registered nurse (RN)-E a clinical administrator had stated would expect when checking refrigerator temperatures if the temperature is too high communicate to clinical coordinators to follow up.

Document review of the facility Medication storage in the facility dated 10/22/13, read, "7. Medications requiring "refrigeration" are kept at temperatures ranging from 36-36 degrees F (2-8 degrees C) in a refrigerator not accessible to residents. Medications requiring storage "in a cool place" are refrigerated unless otherwise directed on the label. Refrigerated medications are kept in closed and labeled containers or compartments with internal and external medications separated,

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and separate from fruit juices, applesauce and other foods used in administering medications."

Expired medications were not removed from possible resident use:

During medication storage tour on 12/3/14, the following had been noted:

At 10:43 a.m., tour with registered nurse (RN)-A of two north medication cart had an opened 30 gram tube of nystatin ointment with an expiration date of 9/13. RN-A verified at the time.

At 11:17 a.m., tour with registered nurse (RN)-B of three south medication cart had an opened bottle of Zeasorb powder (antifungal powder) two percent with and expiration date of 4/10/13 and an opened bottle of ketoconazole two percent (shampoo) with an expiration date of 1/10/13. RN-B verified at the time.

During interview on 12/4/14, at 11:10 a.m., consultant pharmacist (CP)-D had stated the nurse consultant comes quarterly and will go through the medication rooms and the medication carts and will check for expired medications. Otherwise the facility is responsible for expired medications and he would expect them to not use them and get new ones.

During interview on 12/3/14, at 1:58 p.m., RN-E had stated would expect expired medications to be removed from the carts when expired or discontinued.

Document review of the facility EXPIRATION AND BEYOND-USE DATING dated 10/22/13, read, "1. A. Medications that exceed the labeled

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F 431	Continued From page 21 expiration or beyond-use date will be removed from storage and disposed of according to procedure."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		1/13/15

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F 441	Continued From page 22 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to clean nebulizer equipment after administration of medication for 1 of 7 residents (R199) observed during medication administration. Findings include: R199 was observed during medication administration on 12/3/14, at 9:18 a.m., medication assistant (MA)-B prepared medications for R199 and placed one vial of ipratropium albuterol solution (DuoNeb) (a combination of two medicines called bronchodilators) into a plastic nebulizer medication cup, MA-B had attached the mask to the medication cup, placed the mask on R11 and started the nebulizer machine to administer the medication by inhalation. MA-B had stated to R199 it has been 10 minutes we are done and shut off the nebulizer machine, removed the mask from R199 and had set the nebulizer equipment on the nebulizer machine and walked out of R199's room. MA-B verified at the time had not rinsed the nebulizer equipment after administration of medication. During interview on 12/3/14, at 1:58 p.m., registered nurse (RN)-E clinical administrator had stated nebulizer equipment is to be cleaned after administration of medication so time to air dry.	F 441	F441 Staff members caring for R199 were immediately re-educated on the nebulizer rinsing process upon notification. The Nebulizer Policy & Procedure, including nebulizer rinsing has been reviewed and is current. Education regarding cleaning nebulizers after use initiated and ongoing. Audits initiated regarding resident med pass and nebulizer weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is January 13, 2015.	

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F 441	Continued From page 23 Document review of the facility NEBULIZED INHALATION SOLUTION ADMINISTRATION dated revised 10/22/13, read, "In order to ensure safe and effective delivery of inhalation solutions via nebulizer, follow the procedure below: 12. Disconnect nebulizer tubing. Disassemble nebulizer container, mouthpiece/face mask, T-piece, and reservoir tubing, and rinse all parts (except connector tubing) in warm water after each use. Rinse and shake off excess water. 13. Place nebulizer parts on a clean surface to allow to air dry. Reassemble the clean nebulizer parts when ready to use again."	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure safe electrical cords on 2 of 3 food warming carts and 1 of 1 electric can opener cords. This had the potential to effect all staff who had direct contact with these electrical appliances. Findings include: During initial tour on 12/1/14, at 2:40 p.m. the large food warming cart had electrical tape wrapped around the power cord. However, the electrical tape was unraveled exposing wires. Certified dietary manager (CDM)-F confirmed the electrical tape was used and wires were exposed. The medium food warming cart showed a frayed electrical power cord with no electrical tape	F 456	F456 Warming cart and can opener removed and repaired on 12/2/14 and 12/3/14. All kitchen equipment cords audited to ensure essential and safe operating condition. New task monitoring procedure developed for monitoring ongoing compliance. Education for staff initiated on 12/28/14 and is ongoing. Random audits initiated and completed three times weekly for four weeks. Results will be reported to the QA Committee and the need for ongoing audits and action plans initiated as appropriate.	1/13/15

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F 456	Continued From page 24 present. CDM-F verified the cord had exposed wires. Also the electric can-opener had a frayed electrical cord with exposed wires near the plug end. Maintenance records and maintenance policies were not available for this equipment.	F 456	The Nutrition and Culinary Director will be responsible for ongoing compliance. Date certain for ongoing compliance is January 13, 2015	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain food service equipment in a sanitary manner potentially effecting 207 of 207 residents residing in the facility who received food served from the kitchen. Findings include: During initial kitchen tour on 12/1/14, at 2:39 p.m. the following was observed: Large warming food cart showed a build-up of food debris along both bottom side edges. Certified dietary manager (CDM)-F verified observations. Four burners on the gas stove top showed thick black build up. CDM-F stated the burners were cleaned nightly. One of two ovens near the gas stove also showed black/brown food debris at the bottom. CDM-F verified observation and stated they were cleaned nightly. During observation on 12/3/14, at 2:43 p.m.	F 465	F465 Warming food cart, stove top and ovens deep cleaned 12/1/15. Complete kitchen completed to ensure safety, functional, sanitary and comfortable environment maintained for residents. Procedure reviewed, updated to include task sign off checklist and new cleaning procedure initiated and is current. Education for staff initiated on 12/28/14 and is ongoing. Random audits initiated and will be completed three times weekly for four weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. The Nutrition and Culinary Director will be responsible for ongoing compliance. Date certain for ongoing compliance is	1/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	12/05/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 25 kitchen tour observation revealed the following: Oven 2 continued to show dark brown/black debris at the bottom of the oven. Four of front burners on gas stove continued to show black build up and visible grease, one of the four burners showed yellow/orange food crusted food debris. Gas oven had large areas of blackened food debris on the bottom and sides. Large food warming cart continued to have dried food crumbs along both bottom edges. CDM-F confirmed findings and said the need to be cleaned. Facility procedure provided by CDM-F entitled "AM cook work schedule 6:00 AM - 2:30 PM" read, "Empty and wash inside and outside of all hot carts. Daily wipe up any spills that were made in the ovens, work with AM CK being sure that the 2 combi ovens are left clean each day. Clean grill top and 6 burner stove top each day if used." Facility procedure provided by CDM-F entitled "PM cook work schedule starting time 11:15 AM" read, "Cooks and Cook's help are responsible for cleaning the top and bottom of two convection ovens. Also clean combi ovens with cleaner. Clean hot carts."	F 465	January 13, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Presbyterian Home of Arden Hills is a 4-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type II(222) construction. In 2006, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 208 beds and had a census of 204 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET. *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**12/10/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Presbyterian Home of Arden Hills is a 4-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type II(222) construction. In 2006, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 208 beds and had a census of 204 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET. *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 000		

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

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