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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: NTLE

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/24/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

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

13.Total Certified Beds 60 (L17)

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

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 |
|---|---|---|---|---|
| | 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):
At the time of the Standard survey completed on October 24, 2013, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. PCR to follow.

17. SURVEYOR SIGNATURE — Date :
Mary Beth Lacina, HFE NEII — 11/21/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 12/18/2013 (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)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7011 2000 0002 5147 5649

November 6, 2013

Ms. Julie Thompson, Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, Minnesota 55127

RE: Project Number S5613010

Dear Ms. Thompson:

On October 24, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

**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**

**<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.**

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

**DEPARTMENT CONTACT**

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970

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

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 3, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**PLAN OF CORRECTION (PoC)**

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

**Original deficiencies not corrected**

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

**Original deficiencies not corrected and new deficiencies found during the revisit**

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

**Original deficiencies corrected but new deficiencies found during the revisit**

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

**FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by January 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 24, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

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 _____ | 10/24/2013 |

| 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<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | THIS PLAN AND RESPONSE TO THESE SURVEY FINDINGS IS WRITTEN SOLELY TO MAINTAIN CERTIFICATION IN THE MEDICARE PROGRAM. THESE WRITTEN RESPONSES DO NOT CONSTITUTE AN ADMISSION OF NONCOMPLIANCE WITH ANY REQUIREMENT NOR AN AGREEMENT WITH ANY FINDINGS. WE WISH TO PRESERVE OUR RIGHT TO DISPUTE THESE FINDINGS IN THEIR ENTIRETY AT ANY TIME AND IN ANY LEGAL ACTION. WE MAY SUBMIT A SEPARATE REQUEST FOR INFORMAL DISPUTE RESOLUTION FOR CERTAIN FINDINGS AND DETERMINATIONS. | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced | F 425 | 11/18/13 SER | |

RECEIVED
NOV 18 2013
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Administrator | 11/16/13 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245613 | A. BUILDING _____ B. WING _____ | 10/24/2013 |

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

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|---|---|---|---|---|
| F 425 | Continued From page 1<br>by:<br>Based on observation, interview and document review, the facility failed to ensure prescription medications were accurately dispensed for 1 of 2 residents (R110) receiving insulin via a Novolog insulin pen.<br>Findings include:<br>Observation of medication administration on October 21, 2013 at 4:45pm, Licensed Practical Nurse (LPN) A was observed to administer R110 Novolog insulin via a Novolog Flex Pen (a disposable dial-a-dose insulin pen). LPN A was observed to attach the needle to the Flex Pen, dial to 3 units, and administer the insulin to R110 (after wiping R110 ' s skin with an alcohol wipe). Immediately after leaving R110 ' s room, LPN A was interviewed regarding " priming " (also called giving an airshot) the Flex Pen after the needle was attached. LPN A indicated she did not prime the Flex Pen before administering the insulin.<br>Interview with LPN B on 10/22/13 at 2:00 p.m., about administering R110 ' s insulin via the Novolog Flex Pen, LPN B indicated he did not prime the Flex Pen before use.<br>On 10/23/13 at 7:15 a.m., the Policy on administering insulin via Novolog Pen was requested. The Director of Nursing indicated they did not have a specific policy on Novolog Pens, but would get one from the Pharmacy.<br>Review of the manufacturer ' s instructions regarding giving insulin via a Novolog Flex Pen indicated " Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:<br>1. Turn the dose selector to select 2 units.<br>2. Hold you Novolog Flex Pen with the needle pointing up. Tap the cartridge gently with your | F 425 | **F425**<br>Nurse A, Nurse B and all licensed nursing staff were educated/will be educated on accurately dispensing insulin via insulin pen.<br><br>Weekly random audits will be conducted for three months for any residents receiving insulin via insulin pen.<br><br>The Clinical Administrator is responsible for ongoing compliance. Date certain is November 15, 2013 | 11/15/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245613 | A. BUILDING _____ B. WING _____ | 10/24/2013 |

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|---|---|---|---|---|
| F 425 | Continued From page 2 | F 425 | | |

finger a few times to make any air bubbles collect at the top of the cartridge.
3. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. "
Review of R110 ' s physician orders indicated an order for Novolog Insulin: inject 3 units sub-q (subcutaneous) 3 times daily before meals (hold if not eating). The order was from R110 ' s admission on 10/7/13, and was discontinued on 10/21/13.

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 2 000 | Initial Comments | 2 000 | | |

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

11/18/13 SER

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On October 21, 2013 through October 24, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Administrator | 11/6/13

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 2 000 | Continued From page 1<br>Compliance Monitoring, Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900. | 2 000 | The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 21580 | MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements<br><br>Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. | 21580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 21580 | Continued From page 2 | 21580 | | |

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure prescription medications were accurately dispensed for 1 of 2 residents (R110) receiving insulin via a Novolog insulin pen.
Findings include:
Observation of medication administration on October 21, 2013 at 4:45pm, Licensed Practical Nurse (LPN) A was observed to administer R110 Novolog insulin via a Novolog Flex Pen (a disposable dial-a-dose insulin pen). LPN A was observed to attach the needle to the Flex Pen, dial to 3 units, and administer the insulin to R110 (after wiping R110 ' s skin with an alcohol wipe). Immediately after leaving R110 ' s room, LPN A was interviewed regarding " priming " (also called giving an airshot) the Flex Pen after the needle was attached. LPN A indicated she did not prime the Flex Pen before administering the insulin.
Interview with LPN B on 10/22/13 at 2:00 p.m., about administering R110 ' s insulin via the Novolog Flex Pen, LPN B indicated he did not prime the Flex Pen before use.
On 10/23/13 at 7:15 a.m., the Policy on administering insulin via Novolog Pen was requested. The Director of Nursing indicated they did not have a specific policy on Novolog Pens, but would get one from the Pharmacy.
Review of the manufacturer ' s instructions regarding giving insulin via a Novolog Flex Pen indicated " Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:
1. Turn the dose selector to select 2 units.
2. Hold you Novolog Flex Pen with the needle

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 23579 | A. BUILDING: _____ B. WING _____ | 10/24/2013 |

| 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) COMPLETE DATE |
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| 21580 | Continued From page 3<br>pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.<br>3. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. "<br>Review of R110 ' s physician orders indicated an order for Novolog Insulin: inject 3 units sub-q (subcutaneous) 3 times daily before meals (hold if not eating). The order was from R110 ' s admission on 10/7/13, and was discontinued on 10/21/13.<br><br>SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could re-educate the involved staff as to proper procedure for following medication administration. The Director of Nursing could also conduct periodic audits to insure staff compliance with this rule is in place.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21580 | | |

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

F5613008

PRINTED: 11/06/2013
FORM APPROVED
OMB NO. 0938-0391

| 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<br>B. WING _____ | 10/28/2013 |

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

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Presbyterian Homes of North Oaks was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>HEALTH CARE FIRE INSPECTIONS<br>STATE FIRE MARSHAL DIVISION<br>445 MINNESOTA STREET, SUITE 145<br>ST. PAUL, MN 55101-5145<br>or by email to:<br>Barbara.Lundberg@state.mn.us and | K 000 | POC ok<br>FS 11-21-13<br><br>**K029**<br>The first floor storage room by room 88 had the penetrations in the corridor wall around the conduits caulked with 3M Fire Barrier Sealant CP25WB+. The caulking was completed on 11/14/2013. The person responsible for the completion and monitoring of the caulking was Bill Brown, Director of Environmental Services.<br><br>**K038**<br>The Locked Exit Doors to stairwells J and H had the correct exit code mounted and displayed next to the keyless entry pad. This was completed on 11/12/2013. The person responsible for completion and monitoring is Bill Brown, Director of Environmental Services. | |

12-3-13

DC:

EXIT: 10-24-13

RECEIVED
NOV 18 2013
DEPT. OF PUBLIC SAFETY
FIRE MARSHAL DIVISION

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Administrator | 11/16/13 |

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PRESBYTERIAN HOMES OF NORTH OAKS | 5919 CENTERVILLE ROAD<br>NORTH OAKS, MN 55127 |

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| K 000 | Continued From page 1<br>Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Presbyterian Homes of North Oaks is on the 1st floor (ground level) of a 3-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 2005 and was determined to be of Type II(111) construction. In 2008 a 3 story addition was constructed to the East and was determined to be of Type II(111) construction. The nursing home uses only the 1st floor and is fire separated from the other floors. The building is fire sprinklered throughout. 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. Because the original building and the addition meet the construction type allowed for new buildings, the facility was surveyed as one building.<br>The facility has a capacity of 60 beds and had a census of 59 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET. | K 000 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| K 029 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 18.3.6.2. This deficient practice could affect staff patients and visitors within the smoke compartment.<br><br>Findings include:<br>On facility tour between 09:00 AM and 01:00 PM on 10/28/2013, it was observed that the 1st floor Storage Room by room 88, had penetrations in the corridor wall around conduits<br><br>Theis deficiency was verified by Environmental Service Director (BB). | K 029 | | |
| K 038 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1<br><br>This STANDARD is not met as evidenced by:<br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 | K 038 | | |

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|---|---|---|---|---|
| K 038 | Continued From page 3<br>Based on observations, the facility has failed to provide proper exit information on exit doors to the stairwells These deficient practice's could affect the safe and rapid evacuation of residents, visitors and staff within the smoke compartment in the event of an emergency that may require quick evacuation.<br><br>Findings include:<br>On facility tour between 09:00 AM and 01:00 PM on 10/28/2013, it was observed that the Locked Exit Doors to stairwells J and H, did not have instructions on how to open the door restricting multiple means of egress from smoke the compartment. These areas are not in memory loss units.<br><br>This deficiency was verified by Environmental Service Director (BB). | K 038 | | |

MINNESOTA
MDH
DEPARTMENT OF HEALTH

***Protecting, Maintaining and Improving the Health of Minnesotans***

Certified Mail # 7011 2000 0002 5147 5649

November 6, 2013

Ms. Julie Thompson, Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, Minnesota 55127

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5613010

Dear Ms. Thompson:

The above facility was surveyed on October 21, 2013 through October 24, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, PO Box 64900 St. Paul, MN 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 23579 | A. BUILDING: _____ B. WING _____ | 10/24/2013 |

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

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|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On October 21, 2013 through October 24, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of | 2 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. | |

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| 2 000 | Continued From page 1<br>Compliance Monitoring, Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900. | 2 000 | The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 21580 | MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements<br><br>Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. | 21580 | | |

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| 21580 | Continued From page 2<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure prescription medications were accurately dispensed for 1 of 2 residents (R110) receiving insulin via a Novolog insulin pen.<br>Findings include:<br>Observation of medication administration on October 21, 2013 at 4:45pm, Licensed Practical Nurse (LPN) A was observed to administer R110 Novolog insulin via a Novolog Flex Pen (a disposable dial-a-dose insulin pen). LPN A was observed to attach the needle to the Flex Pen, dial to 3 units, and administer the insulin to R110 (after wiping R110 ' s skin with an alcohol wipe). Immediately after leaving R110 ' s room, LPN A was interviewed regarding " priming " (also called giving an airshot) the Flex Pen after the needle was attached. LPN A indicated she did not prime the Flex Pen before administering the insulin.<br>Interview with LPN B on 10/22/13 at 2:00 p.m., about administering R110 ' s insulin via the Novolog Flex Pen, LPN B indicated he did not prime the Flex Pen before use.<br>On 10/23/13 at 7:15 a.m., the Policy on administering insulin via Novolog Pen was requested. The Director of Nursing indicated they did not have a specific policy on Novolog Pens, but would get one from the Pharmacy.<br>Review of the manufacturer ' s instructions regarding giving insulin via a Novolog Flex Pen indicated " Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:<br>1. Turn the dose selector to select 2 units.<br>2. Hold you Novolog Flex Pen with the needle | 21580 | | |

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| 21580 | Continued From page 3<br>pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.<br>3. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. "<br>Review of R110 ' s physician orders indicated an order for Novolog Insulin: inject 3 units sub-q (subcutaneous) 3 times daily before meals (hold if not eating). The order was from R110 ' s admission on 10/7/13, and was discontinued on 10/21/13.<br><br>SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could re-educate the involved staff as to proper procedure for following medication administration. The Director of Nursing could also conduct periodic audits to insure staff compliance with this rule is in place.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21580 | | |