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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P93R

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 **03/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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 :
Susanne Reuss, Unit Supervisor 03/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
02/26/2016
(L33)

Posted 04/06/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245424
March 8, 2016

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 February 14, 2016 the above facility is certified for or recommended 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,

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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

March 8, 2016

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

RE: Project Number S5424025

Dear Ms. Heijerman:

On February 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 14, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 19, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 16, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 14, 2016, effective February 16, 2016 and therefore remedies outlined in our letter to you dated February 2, 2016, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245424	A. Building B. Wing	3/1/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 02/16/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 02/16/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 02/16/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 STATE AGENCY ☑	REVIEWED BY (INITIALS) SR/KJ	DATE 03/08/2016	SIGNATURE OF SURVEYOR 16022	DATE 03/01/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/14/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245424	A. Building 01 - MAIN BUILDING 01 B. Wing	2/19/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 02/15/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 02/15/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 02/15/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/KJ	DATE 03/08/2016	SIGNATURE OF SURVEYOR 12424	DATE 02/19/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/26/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245424	A. Building 02 - 2006 ADDITION B. Wing	2/19/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 02/15/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 02/15/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/KJ	DATE 03/08/2016	SIGNATURE OF SURVEYOR 12424	DATE 02/19/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/26/2016	☐ 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: P93R

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 **01/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Mary Beth Lacina, HFE NE II 02/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 02/24/2016 (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
Posted 02/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 2, 2016

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

RE: Project Number S5424025

Dear Ms. Heijerman:

On January 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 14, 2016 (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 July 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	01/14/2016

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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		2/16/16

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

Electronically Signed | 02/12/2016

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

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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure medications for 1 of 6 residents (R17) reviewed for unnecessary medications was administered per physician ordered parameters. Findings include: Document review on 1/12/15, at 2:00 p.m. indicated R17 had a physician order for Acetaminophen 500 mg (milligrams) Give 2 tablet by mouth every 24 hours as needed for Pain max APAP 4GM/24HRS (maximum acetaminophen 4 grams in 24 hours) and Tylenol Extra Strength Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth three times a day for Pain. Review of R17's medication administration record (MAR) for December 2015, indicated R17 received 2 doses of as needed Acetaminophen in 24 hours on 12/17/15. (5 grams in 24 hours) Review of R17's MAR for November 2015, indicated R17 received 2 doses of as needed Acetaminophen on 11/5/15 (5 grams in 24 hours). Review of R17's MAR for October 2015, indicated R17 received 2 doses of as needed Acetaminophen on 10/1/15 and 10/13/15 (5 grams in 24 hours). Review of R17's MAR for September 2015, indicated R17 received 2 doses of as needed Acetaminophen on 9/6/15, 9/8/15 and 9/15/15 (5 grams in 24 hours). Review of R17's MAR for September 2015,	F 329	Resident # 17 medication regimen was reviewed and all other resident Tylenol orders were reviewed. Requests for Tylenol order(s) to be changed to not greater than 3000mg per day to medical practitioners was initiated on 1/25/16 and order changes are ongoing. License nurse and TMA education on obtaining and following Tylenol parameters, including frequency of medication, and unnecessary medication was initiated on 2/1/16 and is ongoing. Random medication review audits on 10% of residents were initiated on 1/25/16 and will be completed weekly for 1 month by nursing and monthly thereafter by the Pharmacist consultant. Results will be reported to the QA Committee. Actions plans will be developed as needed. The policy for unnecessary medications was reviewed and is current. The Pharmacist consultant will utilize the electronic medical record for review of medication orders for all residents. A monthly recommendation report will be provided to the Clinical Administrator for review and follow up. Care Center Administrator and Clinical Administrator are responsible for ongoing compliance. Date certain for purpose of the ongoing compliance is February 16,	

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F 329	Continued From page 2 indicated R 71 received 2 doses of as needed Acetaminophen on 8/26/15 and 8/29/15 (5 grams in 24 hours). Interview with the Clinical Administrator on 1/14/16, at 9:50 a.m., verified the maximum dose of Tylenol ordered by the physician was exceeded on those dates and he was going to investigate. No further information was provided.	F 329	2016.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 food was prepared under sanitary conditions in 3 of 4 serving kitchens. Findings include: A tour of the facility's serving kitchens was conducted on 1/14/16, from 11:00 a.m. to 11:30 a.m. During the tour the grease catchers on the griddles in the second, third and fourth floor serving kitchens were observed to have an accumulation of brown and black debris	F 371	The second, third and fourth floor serving kitchen griddles were immediately removed and thoroughly cleaned. Staff education initiated on February 1, 2016 and is ongoing. Audits will be completed two times a week for four weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. The Gables Griddle Cleaning Policy and Procedure was reviewed and updated on 1/29/2016 and is current.	2/16/16

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F 371	Continued From page 3 throughout the grease catchers. There was cooked on debris in the corners of each of the griddles grease catchers. On 1/14/16, at 12:27 p.m. the culinary director and administrator verified the condition of each of the griddles. The culinary director stated the griddles were used three times a week and were being cleaned at this time. Also at this time the culinary director provided the surveyor a copy of the facility's undated policy titled, CC Griddle Cleaning Procedure. The policy did not address cleaning of the griddle grease catchers. The culinary manager stated he could revise the policy.	F 371	The Nutrition and Culinary Director will be responsible for compliance by February 16, 2016.	
F 441 SS=E	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	F 441		2/16/16

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F 441	Continued From page 4 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 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 ensure proper infection control techniques were followed to minimize the spread of infection related to storing reusable ice packs with food, in freezers on three floors affecting residents that stored or ate food from the freezers. Findings include: On 1/12/16 at 11:04 a.m., during random observation of second floor south dining room's freezer, 2 unlabeled ice packs were observed to be stored in the refrigerator freezer next to 13 - 4 fluid ounces (fl. oz.) unlabeled frozen nutritional treat. On 1/12/16 at 11:20 a.m., during observation on third floor south dining room's refrigerator's	F 441	The facility initiated immediate correction of ice pack storage on 1/12/16 upon notification. All resident refrigerators were checked and a communication plan on proper ice pack storage was initiated at that time. The policy and procedure was reviewed and updated on 1/29/16 to address storage. Staff education on the updated procedure was initiated on 2/4/16 and is ongoing. Weekly audits will be completed three times weekly for one month by nursing. Results will be reported to the QA committee and the need for ongoing audits and actions plans initiated as needed. Care Center Administrator and Clinical Administrator are responsible for ongoing	

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F 441	Continued From page 5 freezer, 3 unlabeled ice packs were observed to be stored in the refrigerator freezer with 10 - 4 fl. oz. unlabeled frozen nutritional treat, 13 - 4 fl. oz. unlabeled frozen sherbet, 5 unlabeled ice cream coated with orange sherbet, 1 unlabeled pack of raisin bread cinnamon swirl and 11 unlabeled peanut butter & jelly sandwich's. On 1/12/16 at 11:49 a.m., during observation of the refrigerator in the day room on first floor, 4 unlabeled ice packs were observed to be stored in the refrigerator freezer with R161's tomato basil soup. During an interview with registered nurse (RN)-A on 1/12/16, at 11:33 a.m. verified findings and removed the ice packs from the freezer. In addition, RN-A stated, "We do not mix the ice packs and food. During an interview with RN-B on 1/12/16, at 11:42 a.m. confirmed findings, removed the 2 ice packs from the freezer and indicated, "ice packs are not supposed to be stored with food." During an interview with RN-C on 1/12/16, at 11:52 a.m. verified findings, removed R161's tomato basil soup and stated, R161 might have put it in the freezer and maybe R161 did not know, but will let R161 know not to store food with ice packs. During an interview with clinical administrator (CA), on 1/13/16, at 10:54 a.m., CA stated, the ice packs should have been stored separately and initiated reeducation of staff regarding storage of the ice packs. In addition, CA mentioned, "My expectations are ice packs to be stored separately." The facility policy dated December 2014, titled, Ice Packs, reviewed on 1/13/16, at 10:55 a.m. did not address storage of ice packs with food.	F 441	compliance. Date certain for purpose of the ongoing compliance is February 16, 2016.	

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	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Presbyterian Home of Arden Hills was found not 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 19 EXISTING Health Care and Chapter 18 NEW Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

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

Electronically Signed — 02/12/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 198 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		2/15/16

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	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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K 011 SS=D	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the 2-hour fire separation at the required location. This deficient practice could affect the safety of all residents, in the event of a fire, as fire and smoke could pass from one building to the other. Findings include: On facility tour between 9:30 AM and 2:30 PM on 01-26-2016, it was observed that the 2-hour fire separation wall above the rate doors had penetrations around conduit and wires.. This deficiency was verified by Environmental Service Director (TC) at the time of discovery.	K 011	The environmental services director will ensure that the penetrations above the rated door in the fire separation wall in the lower level are sealed using the proper UL listed system for the penetration type and wall fire rating. The environmental services director will conduct an inspection of smoke and fire rated walls whenever a contractor has worked in the vicinity of a rated wall and may have left an unsealed penetration.	
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		2/15/16

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K 062	Continued From page 3 Based on Documentation, observation and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 9:30 AM and 2:30 PM on 01-26-2016, it was noted during documentation review and observation, that the sprinkler gauge has not been calibrated or replaced in the last 5 years. This deficiency was confirmed by Environmental Service Director (TC) at the time of discovery.	K 062	The environmental services director will ensure that the sprinkler system main valve pressure gauge will be calibrated or replaced as required by the NFPA 101 LSC (2000). The environmental services director will enter a task into the electronic work order scheduling system for sprinkler system inspections at the appropriate times as required by the NFPA 101 LSC (2000). The regional engineering department will ensure that the preventative maintenance tasks for fire life safety items are completed in the timeframes required by the NFPA 101 LSC (2000).	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 64 residents. Findings include: On facility tour between 9:30 AM and 2:30 PM on	K 144	The environmental service director and the regional engineering department will develop a generator log that will document the information as required by the NFPA 101 LSC (2000) including an entry for the cool down period. The regional engineer will be responsible for the design of the log sheet, and the environmental services director will be responsible for	2/15/16

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K 144	Continued From page 4 01-26-2016, documentation review of the inspection logs for the emergency generator revealed that There was no documentation of the minimum 5 minute cool down time after the generator is run under load. This deficiency was confirmed by Environmental Service Director (TC) at the time of discovery.	K 144	implementing the new log sheet for both generators and ensuring all the required data is recorded.	

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	245424	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**01/26/2016**

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 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Presbyterian Home of Arden Hills was found not 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 19 EXISTING Health Care and Chapter 18 NEW Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2016

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 _____	**01/26/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 198 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		2/15/16

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	245424	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**01/26/2016**

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K 062 SS=C	Continued From page 2 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on Documentation, observation and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 9:30 AM and 2:30 PM on 01-26-2016, it was noted during documentation review and observation, that the sprinkler gauge has not been calibrated or replaced in the last 5 years. This deficiency was confirmed by Environmental Service Director (TC) at the time of discovery.	K 062	The environmental services director will ensure that the sprinkler system main valve pressure gauge will be calibrated or replaced as required by the NFPA 101 LSC (2000). The environmental services director will enter a task into the electronic work order scheduling system for sprinkler system inspections at the appropriate times as required by the NFPA 101 LSC (2000). The regional engineering department will ensure that the preventative maintenance tasks for fire life safety items are completed in the timeframes required by the NFPA 101 LSC (2000).	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff	K 144	The environmental service director and	2/15/16

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K 144	Continued From page 3 interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 64 residents. Findings include: On facility tour between 9:30 AM and 2:30 PM on 01-26-2016, documentation review of the inspection logs for the emergency generator revealed that There was no documentation of the minimum 5 minute cool down time after the generator is run under load. This deficiency was confirmed by Environmental Service Director (TC) at the time of discovery.	K 144	the regional engineering department will develop a generator log that will document the information as required by the NFPA 101 LSC (2000) including an entry for the cool down period. The regional engineer will be responsible for the design of the log sheet, and the environmental services director will be responsible for implementing the new log sheet for both generators and ensuring all the required data is recorded.	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
February 2, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5424025

Dear Ms. Heijerman:

The above facility was surveyed on January 11, 2016 through January 14, 2016 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, Health Regulation 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.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute 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.

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

Enclosure(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
	00975	A. BUILDING: _____ B. WING _____	01/14/2016

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/11/2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was prepared under sanitary conditions in 3 of 4 serving kitchens. Findings include: A tour of the facility's serving kitchens was conducted on 1/14/16, from 11:00 a.m. to 11:30 a.m. During the tour the grease catchers on the griddles in the second, third and fourth floor serving kitchens were observed to have an accumulation of brown and black debris throughout the grease catchers. There was cooked on debris in the corners of each of the griddles grease catchers. On 1/14/16, at 12:27 p.m. the culinary director and administrator verified the condition of each of the griddles. The culinary director stated the griddles were used three times a week and were being cleaned at this time.	21015	Corrected	2/16/16

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21015	Continued From page 3 Also at this time the culinary director provided the surveyor a copy of the facility's undated policy titled, CC Griddle Cleaning Procedure. The policy did not address cleaning of the griddle grease catchers. The culinary manager stated he could revise the policy. SUGGESTED METHOD OF CORRECTION: The culinar director should revise the facility's policy on griddle cleaning to include cleaning of the grease catchers. Dietary staff using the griddles to prepare food should be educated on the new policy and procedure. The culinary director or designee could randomly observe cleaning of the griddles and/or observe the griddles for cleanliness TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in	21390		2/16/16

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21390	Continued From page 4 the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control techniques were followed to minimize the spread of infection related to storing reusable ice packs with food, in freezers on three floors affecting residents that stored or ate food from the freezers. Findings include: On 1/12/16 at 11:04 a.m., during random observation of second floor south dining room's freezer, 2 unlabeled ice packs were observed to be stored in the refrigerator freezer next to 13 - 4 fluid ounces (fl. oz.) unlabeled frozen nutritional treat. On 1/12/16 at 11:20 a.m., during observation on third floor south dining room's refrigerator's freezer, 3 unlabeled ice packs were observed to be stored in the refrigerator freezer with 10 - 4 fl. oz. unlabeled frozen nutritional treat, 13 - 4 fl. oz. unlabeled frozen sherbet, 5 unlabeled ice cream coated with orange sherbet, 1 unlabeled pack of	21390	Corrected	

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21390	Continued From page 5 raisin bread cinnamon swirl and 11 unlabeled peanut butter & jelly sandwich's. On 1/12/16 at 11:49 a.m., during observation of the refrigerator in the day room on first floor, 4 unlabeled ice packs were observed to be stored in the refrigerator freezer with R161's tomato basil soup. During an interview with registered nurse (RN)-A on 1/12/16, at 11:33 a.m. verified findings and removed the ice packs from the freezer. In addition, RN-A stated, "We do not mix the ice packs and food. During an interview with RN-B on 1/12/16, at 11:42 a.m. confirmed findings, removed the 2 ice packs from the freezer and indicated, "ice packs are not supposed to be stored with food." During an interview with RN-C on 1/12/16, at 11:52 a.m. verified findings, removed R161's tomato basil soup and stated, R161 might have put it in the freezer and maybe R161 did not know, but will let R161 know not to store food with ice packs. During an interview with clinical administrator (CA), on 1/13/16, at 10:54 a.m., CA stated, the ice packs should have been stored separately and initiated reeducation of staff regarding storage of the ice packs. In addition, CA mentioned, "My expectations are ice packs to be stored separately." The facility policy dated December 2014, titled, Ice Packs, reviewed on 1/13/16, at 10:55 a.m. did not address storage of ice packs with food. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could conduct refrigerator/freezer audits, interventions	21390		

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21390	Continued From page 6 and monitoring to ensure residents cold packs are not stored with food. The DON could ensure the staff were educated on the importance of infection control and individual resident ice packs in the freezer contaminating food items. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21426	Corrected	2/16/16

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21426	Continued From page 7	21426		

review, the facility failed to document the induration measurement of millimeter (mm) results of tuberculin skin test (TST) for 5 of 5 residents reviewed, (R10, R35, R36, R61 and R195), per Centers for Disease Control and Prevention (CDC) recommendations.

Findings include:

R10 was admitted to the facility on 10/15/15. R10's medical record indicted R10 received the first step of TST, the results were read on 10/16/15 as negative interpretation. R10 then received the second step TST, results were read on 10/26/15, as negative interpretation however no induration was indicated on both.

R35 was admitted to the facility on 2/5/14. R35's medical record indicted R35 received the first step of TST on 2/6/15, and the results were read as negative interpretation of reading on 2/9/15. R35 then received the second step TST on 2/19/15, results were read on 2/22/15 as negative interpretation however no induration was indicated on both.

R36 was admitted to the facility on 2/17/15. R36's medical record indicted R36 received the first step of TST, the results were read on 12/18/15 as negative interpretation. R36 then received the second step TST, results were read on 3/25/15 as negative interpretation however no induration was indicated on both.

R61 was admitted to the facility on 7/31/15. R61's medical record indicted R61 received the first step of TST, the results were read on 8/1/15 as negative interpretation however no induration was indicated. R61 then received the second step TST, results were read on 8/5/15 as 0 mm with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00975	A. BUILDING: _____ B. WING _____	01/14/2016

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) COMPLETE DATE
21426	Continued From page 8 negative interpretation. R195 was admitted to the facility on 12/9/13. R195's medical record indicted R195 received the first step of TST on 12/10/13, and the results were read as negative interpretation of reading on 12/13/13. R195 then received the second step TST on 12/21/13, results were read on 12/24/13 as negative interpretation however no induration was indicated on both. On 1/13/16 at 10:27 a.m. the clinical administrator (CA) acknowledged the TST reading for R10, R35, R36, R61 and R195 should have both the induration and interpretation. CA stated, resident's records are lacked of the induration measurement of mm. In addition, CA mentioned, going forward, the software will be updated to prompt the staff to record both the induration measurement of mm and interpretation of positive or negative. Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening residents directed, ALL REPORTS OR COPIES OF THE TST OR IGRA AND ANY CHEST X-RAYS AND MEDICAL EVALUATIONS CONDUCTED SHOULD BE MAINTAINED IN THE RESIDENT'S MEDICAL RECORD. TST DOCUMENTATION FOR RESIDENTS SHOULD INCLUDE THE DATE (I.E., MONTH, DAY, YEAR), THE NUMBER OF MILLIMETERS OF INDURATION (IF NO INDURATION, DOCUMENT "0" MM), AND INTERPRETATION (I.E., POSITIVE OR NEGATIVE). IF THIS INFORMATION IS NOT AVAILABLE, DOCUMENTATION OF A HISTORY OF INFECTION WITH TB (E.G., A PREVIOUS POSITIVE SKIN TEST OR HISTORY OF ACTIVE TB DISEASE) BY A PHYSICIAN IN THE	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00975	A. BUILDING: _____ B. WING _____	01/14/2016

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(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
21426	Continued From page 9 RESIDENT'S MEDICAL RECORD IS ACCEPTABLE. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could conduct resident tuberculin skin testing audits, interventions and monitoring to ensure residents are free from communicable disease. The DON could ensure the staff were educated on the importance of induration tuberculin testing. The DON or designee could randomly audit resident's to ensure adequate measurements of induration are documented. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21426		