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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S44H

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 **02/01/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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

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 :
Cynthia Wentkiewicz, HFE NE II 02/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 07/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
01/24/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245424
February 17, 2017

Ms. Heather Heijerman, Administrator
Presbyterian Homes of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 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 3, 2017 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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 17, 2017

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

RE: Project Number S5424026

Dear Ms. Heijerman:

On December 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 8, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 7, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 3, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 8, 2016, effective February 3, 2017 and therefore remedies outlined in our letter to you dated December 19, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245424	A. Building B. Wing	2/1/2017

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 F0282 Reg. # 483.21(b)(3)(ii) LSC	Correction Completed 02/01/2017	ID Prefix F0312 Reg. # 483.24(a)(2) LSC	Correction Completed 02/01/2017	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) SR/KJ	DATE 02/17/2017	SIGNATURE OF SURVEYOR 34986	DATE 02/01/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/8/2016	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245424 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/7/2017 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0133	02/03/2017	LSC K0345	02/03/2017	LSC K0372	02/03/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0521	02/03/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	02/17/2017	37008	02/07/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/7/2016

☐ 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: S44H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00975

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245424**

2.STATE VENDOR OR MEDICAID NO.
(L2) **369842400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/08/2016** (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 Capes, HFE NE II — 12/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/23/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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 01/24/2017 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
December 19, 2016

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

RE: Project Number S5424026

Dear Ms. Heijerman:

On December 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by NO DATA, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 8, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

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 _____	12/08/2016

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 A recertification survey was conducted December 5th, 6th, 7th, and 8th, 2016. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with residents written plan of care for 2 of 4 residents (R241, R80) who required assist with shaving. Findings include:	F 282	Resident 241 & Resident 80 were assisted with shaving of unwanted facial hair upon identification. Staff education regarding following the care plan, providing grooming and hygiene and documentation was conducted with staff involved immediately. The care plans, My Best Days and Point of Care tasks were	1/10/17

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

Electronically Signed | 12/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	12/08/2016

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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F 282	Continued From page 1 R241's care plan dated 11/1/16, identified R241 had alteration in hygiene/ADL's/shower/bath and directed staff, "I require staff assistance with dressing, grooming, and bathing. PERSONAL HYGIENE/ORAL CARE: I require setup/supervision, with 1 staff participation to complete tasks as needed..." My Best Day updated 12/7/2016, read, "Dressing/Grooming: AO1 [assist of one]. Shave chin daily." On 12/5/2016 at 6:37 p.m., R241, was observed to have several gray/white facial hairs to the upper lip and the chin area approximately one half inch long. Resident was unable to communicate her needs when queried at the time. On 12/6/16 at 12:05 p.m., R241 was observed in her room sitting in chair watching television and was observed to still have numerous facial hairs. On 12/7/16 at 9:43 a.m., R241 was observed in her room sitting in chair and was witnessed to still have numerous facial hairs. On 12/7/16 at 10:40 a.m. RN-A verified that R241 had facial hair, was unshaven and stated, her expectation is that R241 should be shaved everyday according to the care plan and explained that shaving is part of grooming. On 12/7/16 at aproximately10:50 a.m., director of nursing (DON), stated, "My expectation is staff needs to observe that and offer to remove it and if resident refuses, it should be documented in the clinical record."	F 282	reviewed for activities of daily living (ADL□s) and were current for resident specific needs and desires. Staff education was initiated on 12/7/16 that included the providing ADLs for residents including offering to remove facial hair, following the care plan and expectations of documentation. Additionally the household-level leadership of Resident Services and Clinical Coordinator conducted observations on all residents to ensure facial hair had been removed per resident plan of care on 12/7/16. Ongoing education on providing care according to the care plans has been initiated for nursing staff on 12/22/2016 that included a review of the facilities policy entitled "Cares AM and HS". The applicable polices have been reviewed and are current. Each resident is assessed for care needs and the care plan updated upon admission, quarterly, annually and with a significant change of condition in conjunction with the RAI process. All nursing staff are trained on providing cares per the care plan upon hire as needed and minimally annually through competency class and performance observations. Audits regarding care plan interventions being followed by direct observation of cares will be conducted on 10% of	

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F 282	Continued From page 2 R80's care plan dated 2/12/16, identified that R80 had an alteration in hygiene/ADL's/shower/bath and directed staff, PERSONAL HYGIENE/ORAL CARE: "I require 1 staff participation with personal hygiene and oral care." My Best Day was requested from registered nurse (RN)-A on 12/7/16 at 10:24 a.m., but was not received. On 12/5/16 at 6:31 p.m., R80 was observed to have several gray/white facial hairs to the upper lip and the chin area. Resident was able to communicate needs with some confusion. On 12/6/16 at 12:08 p.m., R80 was seen in dining room sitting in chair and was observed to still have numerous facial hairs. On 12/7/16 at 9:08 a.m., R80 was seen in dining room sitting in chair and was observed to still have numerous facial hairs. On 12/7/16 at 10:09 a.m., during interview, nursing assistant (NA)-A verified that R80 was unshaven and stated that he did not shave R80 yesterday or today because R80 usually refuses and that he documented this in point of click care (POC). On 12/7/16 at 10:24 a.m. RN-A verified that R80 had facial hair and was unshaven and stated, according to NA-A, R80 refused to be shaved yesterday and today and NA-A had documented this, however review of the POC identified that NA-A had documented that he had shaved R80 on 12/6/16 and 12/7/16. RN-A added, her expectation is that R80 should be shaved everyday, according to My Best Day, the care	F 282	residents weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 1/10/2017.	

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F 282	Continued From page 3 plan and POC and if R80 refuses, to notify the nurse and re-approach.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document reviewed, the facility failed to provide personal hygiene care for 2 of 4 residents (R241, R80) who were dependent upon staff for personal cares. Findings Include: R241 was observed to have several facial hairs the evening of 12/5/16, and during subsequent days of the survey on 12/6/16 and 12/7/16. On 12/5/2016 at 6:37 p.m., R241 was observed to have several gray/white facial hairs to the upper lip and the chin area approximately one half inch long. Resident was unable to communicate her needs when queried at the time. On 12/6/16 at 12:05 p.m., R241 was observed in her room sitting in chair watching television and was observed to still have numerous facial hairs. On 12/7/16 at 9:43 a.m., R241 was observed in her room sitting in chair and was observed to still have numerous facial hairs.	F 312	Resident 241 & Resident 80 care plans, My Best Days and Point of Care tasks were reviewed for activities of daily living (ADL□s) and were current to reflect resident needs. As part of an immediate plan of correction Resident 241 & 80 were provided with these cares. The facility initiated staff education on 12/7/16 that included the providing ADLs for residents including offering to remove facial hair, following the care plan and documentation. Additionally the household-level leadership of Resident Services and Clinical Coordinator conducted observations on all residents to ensure facial hair had been removed per resident plan of care on 12/7/16. The applicable policies for providing grooming and hygiene and care planning were reviewed and are current. Education on providing ADL□s for dependent residents per the care plan has been initiated on 12/22/16 and is ongoing. Each resident is assessed for care needs	1/10/17

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F 312	Continued From page 4 R241's clinical record noted R241 was admitted to facility on 7/22/16, and had diagnoses, which included Dementia without behavioral disturbance. R241's quarterly Minimum Data Set (MDS) dated 10/28/16, identified R241 required extensive assist of one staff with bed mobility, dressing, and personal hygiene needs. The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 8/2/16, indicated, "[R241] triggers for ADLs as she has needed up to A1 (assist of one) with all ADLS." The care plan dated 11/1/16, identified R241 had alteration in hygiene/ADL's/shower/bath and directed staff, "I require staff assistance with dressing, grooming, and bathing. PERSONAL HYGIENE/ORAL CARE: I require setup/supervision, with 1 staff participation to complete tasks as needed..." My Best Day updated 12/7/2016, reads, "Dressing/Grooming: AO1 [assist of one]. Shave chin daily." On 12/7/16 at 10:40 a.m., RN-A verified that R241 had facial hair and was unshaven and stated, her expectation is that R241 should be shaved everyday according to the care plan and shaving is part of grooming. On 12/7/16 at 10:50 a.m. and at 10:57 a.m., director of nursing (DON), stated, "My expectation is staff need to observe that and offer to remove it and if resident refuses, it should be documented in the clinical record."	F 312	and the care plan updated upon admission, quarterly, annually and with a significant change of condition in conjunction with the RAI process. All nursing staff are trained on providing cares per the care plan upon hire as needed and minimally annually through competency class and performance observations. Audits to monitor staff are providing activities of daily living to residents who are unable to carry out independently to maintain good nutrition, grooming, and personal and oral hygiene will be conducted on 10% of residents weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Date certain for the purposes of ongoing compliance is 1/10/2017.	

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F 312	Continued From page 5 Policy and procedure titled CARES AM AND HS reviewed date 9/2015, reads, "Every resident is to have AM and HS cares done daily. 2. Review My Best Day or Nursing Assistant Assignment Sheet for the amount of assistance required to provide care and resident's ability to participate. 11. Shave resident's in am and apply makeup to female guests as requested." R80 was observed to have several facial hairs the evening of 12/5/16, and during subsequent days of the survey on 12/6/16 and 12/7/16. On 12/5/16 at 6:31 p.m., R80 was observed to have several gray/white facial hairs to the upper lip and the chin area. Resident was able to communicate needs with some confusion. On 12/6/16 at 12:08 p.m., R80 was seen in dining room sitting in chair and was observed to still have numerous facial hairs. On 12/7/16 at 9:08 a.m., R80 was seen in dining room sitting in chair and was observed to still have numerous facial hairs. R80's quarterly Minimum Data Set (MDS) dated 10/18/16, identified R80 requires extensive assist of one staff with personal hygiene needs. The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 4/27/16, indicated, R80 has, dementia, requires assist of one for grooming, bathing and dressing. The care plan dated 2/12/16, identified R80 had alteration in hygiene/ADL's/shower/bath and	F 312		

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F 312	Continued From page 6 directed staff, "I have an ADL Self Care Performance Deficit r/t Dementia, Limited Mobility, depression I frequently refuse my bath. If I refuse try multiple approaches and report to nurse if I refuse. PERSONAL HYGIENE/ORAL CARE: I require 1 staff participation with personal hygiene and oral care." My Best Day requested from registered nurse (RN)-A on 12/7/16 at 10:24 a.m., but was not received. On 12/7/16 at 10:09 a.m., during interview with nursing assistant (NA)-A verified that R80 was unshaven and stated that he did not shave R80 yesterday or today because R80 usually refuses and indicated that he documented this in the point of click care (POC). On 12/7/16 at 10:24 a.m. RN-A verified that R80 had facial hair and was unshaven and stated that, according to NA-A, R80 refused to be shaved yesterday and today and that NA-A had documented that. Review of the POC revealed that documentation indicated R80 had been shaved on 12/6/16 and 12/7/16. RN-A added, her expectation is that R80 should be shaved everyday according to My best day, the care plan and POC and if R80 refuses to notify the nurse and to re-approach.	F 312		

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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 dated 12-7-16, 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 2012 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		

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

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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. separate buildings. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 208 beds and had a census of 204 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=D	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance	K 133		2/3/17

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K 133	Continued From page 2 with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 On facility tour between 09:00 AM and 01:00 PM on Dec. 7, 2016, based on observation and interview revealed or based on documentation review and interview that the findings include: Observation during the inspection that the 2-hour fire wall on the Lower Level to assisted living had penetration in wall.	K 133	The wall in the loading dock/storeroom area with the penetration noted during the LSC inspection is not part of the care center two hour separation barrier between the care center and the assisted living occupancies. The Regional Engineering Manager will work with and train the site Environmental Services Director to ensure he is aware of requirements of the two hour occupancy separation in general, and where the two hour occupancy separation is specifically in this building. The smoke compartment and fire barrier walls will be clearly marked on building floor maps and the maps will be available for review during the annual life safety code survey. These maps with smoke and fire barriers marked will be kept in the Life Safety Code Documentation Manual. The Presbyterian Homes Regional Engineering Manager and the site Environmental Services Director will be	

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K 133	Continued From page 3 This deficient practice could affect the safety of all the staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 133	responsible for the accuracy and availability of these maps.	
K 345 SS=C	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 On facility tour between 09:00 AM and 01:00 PM on Dec. 7, 2016, based on documentation review and interview that the findings include: That the Facility does not a current copy of the sensitivity testing on all smoke detectors	K 345	The fire alarm system yearly inspection documentation will include all necessary inspection forms including a printout of the current sensitivity level of all smoke detectors as required by NFPA 72(10) Beginning with the 2017 fire alarm system inspection documentation, The sensitivity report will be included. Subsequent yearly inspection sensitivity reports will be included as required to be available during the annual LSC inspection. The Environmental Services Director will be responsible to acquire this report from	2/3/17

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K 345	Continued From page 4 This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. Documentation review indicated that the Facility does not a current copy of the sensitivity testing on all smoke detectors.	K 345	the fire alarm system inspection company and include it in the documentation of the yearly fire alarm system inspection.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		2/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/07/2016**

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 372	Continued From page 5 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. On facility tour between 09:00 AM and 01:00 PM on Dec. 7, 2016, based on observation and interview revealed that the findings include: Observation during the inspection that the fire barrier on 1st. floor by Beauty shop can not be verified as to correct location. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372	The smoke compartment barrier walls will be clearly marked on building floor maps and the maps will be available for review during the annual life safety code survey. These maps with smoke and fire barriers marked will be kept in the Life Safety Code Documentation Manual. The Presbyterian Homes Regional Engineering Manager and the site Environmental Services Director (ESD) will be responsible for the accuracy of these maps. The ESD will be responsible to ensure that the current documentation is available for review by the LSC surveyor.	
K 521 SS=C	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's	K 521		2/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/07/2016**

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 521	Continued From page 6 specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 On facility tour between 09:00 AM and 01:00 PM on Dec.7, 2016, based on documentation review and interview that the findings include: Documentation review indicated that the Facility does not a current copy of fire damper testing This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 521	An inspection of the fire dampers will be done as required by NFPA 101(12). An automatically recurring entry will be made in the Electronic Work Order System to ensure this inspection is completed when required by the Life Safety Code. Documentation of this inspection will be kept in the Life Safety Code Documentation Manual and be available for review during the annual life safety code surveys. The Environmental Services Director (ESD) will be responsible for ensuring that the required inspections are carried out and the ESD will be responsible to ensure that the current documentation is available for review by the LSC surveyor.	