Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 30, 2023

Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: CCN: 245424
Cycle Start Date: July 26, 2023

Dear Administrator:

On September 18, 2023, we notified you a remedy was imposed. On October 24, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 18, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 26, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 2, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 26, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 18, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 30, 2023

Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

Re: Reinspection Results
Event ID: VSRT12

Dear Administrator:

On October 24, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 30, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 18, 2023

Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: CCN: 245424
Cycle Start Date: July 26, 2023

Dear Administrator:

On August 2, 2023, we informed you that we may impose enforcement remedies.

On August 30, 2023, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 26, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 26, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 26, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 26, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Presbyterian Homes Of Arden Hills will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 26, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 January 26, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 18, 2023

Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: VSRT11

Dear Administrator:

The above facility was surveyed on August 27, 2023 through August 30, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 08/30/2023

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
E 000	Initial Comments On 8/27/23-8/30/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/27/23-8/30/23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. The following complaint was reviewed: H54244864C (MN86894) 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550	Resident Rights/Exercise of Rights	F 550		10/13/23

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

Electronically Signed | 09/28/2023

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
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F 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550		

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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 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 2 of 2 residents (R6, R8) reviewed for dignity. Findings include: R8's annual Minimum Data Set (MDS) dated 6/21/23, indicated R8 had severe cognitive impairment, did not reject care and it was somewhat important to choose what clothes to wear, was totally dependent on staff for personal hygiene to include shaving. R8's diagnoses included: non traumatic brain dysfunction, unspecified dementia, diabetes mellitus, depression, and hemiplegia or hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). R8's care plan dated 6/27/23, indicated R8 wanted to be clean and well dressed daily. Further, R8 wore a wig that was to be on in the a.m., and off at bedtime, and required two staff participation with personal hygiene and oral care. Additionally, R8 had physical behaviors of striking out, hitting and scratching staff during cares due to dementia and depression with interventions included to allow R8 to make choices when possible about cares and activities, and document observed behavior and attempted interventions per policy. Further, indicated R8 had an alteration in blood glucose related to a diagnoses of diabetes and with an intervention of	F 550	The facility continues to follow the Resident Care Policy which focuses on every resident was to have morning and bedtime cares daily, including shaving female residents in the morning and applying makeup as requested. The facility continues to follow the Catheter –Care of Indwelling Cath Policy for those residents with catheters. Which does state the catheter should be placed in a cloth bag when up in chair or bed and to never raise the catheter bag above the level of the bladder. R8 was shaved on 8/30 when it was brought to clinical administrator's attention. The facility has changed to electric shavers for all residents. Nursing Assistants are allowed to utilize electric razors to complete assistance with shaving even for residents with diabetes as directed on the plan of care. The Care Plan was updated to reflect these changes. The facility was not aware that during survey, that only one bath was given in the month of August. Facility reviewed her body audits which did note she had baths on 8/1/2023, 8/7/2023, 8/14/2023, 8/21/2023, and 8/28/2023 with no refusals noted. R6 remains a resident in the facility and has had no psychosocial impact noted	

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F 550	Continued From page 3 a nurse would provide nail care. The care plan lacked an intervention for shaving. R8's care sheet undated, indicated R8 wore a wig during the day and was removed at bedtime, received a bath on Monday a.m., was on bleeding and bruising precautions due to being on a blood thinning medication, and the nurse was to trim nails due to a diagnosis of diabetes. The care sheet lacked instruction for staff to remove R8's facial hair. R8's Target Behavior form from 8/1/23 to 8/30/23, indicated behaviors occurred on 8/7/23, 8/12/23, 8/13/23, and 8/26/23. The rest of the time frame indicated behaviors were documented as "did not occur" 55 times or "not applicable" 25 times. R8's Bath form from 8/1/23, to 8/30/23, indicated R8 received a bath on 8/14/23. No additional baths were documented during the time frame. Additionally, there were no documented refusals. R8's clinical physician orders dated 1/9/23, was reviewed and included an order to trim finger nails during shift every Monday and ask for nursing assistant (NA) assistance as needed. The Clinical Physician Orders form was reviewed and lacked any instruction for removing R8's facial hair. R8's medication administration record (MAR) and treatment administration record (TAR) for August 2023, was reviewed and lacked instruction for removing R8's facial hair. During observation on 8/27/23 at 3:45 p.m., R8 was observed to have a dark mustache on her upper lip and around her mouth.	F 550	from the failing to have their catheter covered. It is the expectation of Johanna Shores Care Center that staff will help protect resident rights and to provide residents cares to ensure their dignity is maintained. Education on resident rights and dignity was initiated for all nursing staff. Other residents were reviewed to ensure their grooming preferences in regard to facial hair is care planned and that facility staff are following those wishes. All residents were reviewed to ensure nail care was completed with their last scheduled bath day. If the resident is Diabetic that nail care was completed by a nurse on their bath day. Facility ensured each care plan/care sheets of residents affected were updated. Facility completed an audit of all residents with catheters to ensure they had privacy catheter bags. Education will be completed for staff on catheter care and using catheter bags and hanging them appropriately. Facility ensured each care plan/care sheets of residents affected were updated. Random audits initiated and will be completed on 10% of residents for compliance weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and actions plans initiated as appropriate. Clinical Administrator) will be responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PRESBYTERIAN HOMES OF ARDEN HILLS	3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

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F 550	Continued From page 4 During observation on 8/29/23 at 7:16 a.m., R8 was up in her wheelchair and observed R8 to have a dark mustache. During observation on 8/30/23 at 8:31 a.m., R8 was at the dining room table and had a visible dark mustache noted and R8 was wearing her black colored wig. During interview 8/29/23 at 9:42 a.m., nursing assistant (NA)-B stated they looked at care sheets in order to know what kind of cares a resident required. During interview on 8/29/23 at 9:54 a.m., NA-B stated she did not shave R8 because a nurse needed to shave R8 because she could not risk cutting R8. During interview on 8/30/23 at 9:13 a.m., registered nurse (RN)-D stated she looked to the care plan to know what kind of cares a resident received and stated women were shaved on their bath day and added if a resident was diabetic, the nurse completed shaving. After asking about R8's bath day, RN-D stated it had been a while and if the resident had an electric razor, the NA could shave the resident and stated R8 had an electric razor and therefore the aide was responsible for shaving R8. LPN-A stated when someone refused cares, it was documented. During interview and observation on 8/30/23 at 9:26 a.m., RN-D verified there was no electric shaver in R8's room and at 9:30 a.m., verified R8 had facial hair and stated R8 should be shaved. During interview on 8/30/23 at 9:31 a.m.,	F 550	for ongoing compliance. Date for compliance is 10/13/2023.	

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F 550	Continued From page 5 registered nurse (RN)-B stated R8 was diabetic and there was no specific assignment for shaving, but thought it was the nurse's responsibility and if R8 refused, expected documentation of refusals from all staff. RN-B verified there was no specific task for shaving on the care plan or care sheet, no bath documented since 8/14/23 for R8, no documentation the past three to four months regarding any refusals for shaving, and stated they should have a scheduled task for shaving because the task could get missed if it was not identified on the care plan and care sheet. RN-B added a female resident would not want facial hair. During interview on 8/30/23 at 9:47 a.m., the director of nursing (DON) stated the aide was responsible for shaving, but if a resident was diabetic, it was the nurse's responsibility. DON stated women should be shaved as needed and expected shaving be completed on bath days adding it was a dignity issue for a female to have facial hair. . R6's significant change Minimum Data Set (MDS), dated 7/26/23, indicated R6 was cognitively intact, and required extensive assist of one staff for toileting and personal hygiene.	F 550		

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F 550	Continued From page 6 R6's face sheet printed 8/30/23, indicated resident diagnosis included congestive heart failure (CHF), urinary tract infection, and atrial fibrillation. R6's bladder care plan revised on 7/31/23, indicated R6 is occasionally incontinent of bowel and bladder, with goal that included would be free from skin breakdown due to incontinence and from brief use through review date. R6 catheter updated 8/27/23, indicated I have (SIC) catheter or urostomy with interventions that included position catheter bag and tubing below the level of the bladder. Catheter care per facility policy. R6's physician orders dated 8/4/23, included catheter care every shift and as needed. Document output in point of care (POC) record two times a day for catheter maintenance. Catheter bag and/or leg bag covered at all times. During observation and interview on 8/27/23 at 3:11 p.m., R6's catheter was attached to the side of her wheelchair (w/c) and not in a privacy bag. R6's catheter could be seen from the doorway. During interview, R6 stated, she would prefer the catheter bag be placed in a privacy bag. During observation on 8/29/23 at 1:09 p.m., R6's catheter was attached to the side of her W/C, hooked onto a bag attached to the top side rail attachment on W/C. R6's catheter tubing and catheter bag were at the level of her bladder; catheter bag was not in privacy bag.	F 550		

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F 550	Continued From page 7 During interview on 8/30/23 at 10:50 a.m., nursing assistant (NA)-F verified catheter bag was not in privacy bag or below the bladder as should have been to allow urine to drain into the bag. During interview on 8/30/23 at 4:17 p.m., director of nursing (DON) stated, it was the expectation catheter bags were placed in privacy bags and placed below the bladder to prevent urine backing up into the bladder. A policy, Resident Care Policy dated February 2016, indicated every resident was to have morning and bedtime cares daily. The procedure included shaving female residents in the am and applying makeup as requested. A policy, Dignity dated September 2015, indicated residents were cared for in a manner and in an environment that promoted maintenance and or enhancement of each resident's quality of life Facility policy titled Catheter- Care of Indwelling Cath Policy modified on 6/2021, indicated catheter is placed in cloth bag when up in wheelchair and when in bed. Never raise a catheter bag above the level of the bladder. This could increase the chance of a bladder infection.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 554		10/13/23

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F 554	Continued From page 8 Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R25, R98) had been assessed to safely self-administer medications. Findings include: R25's quarterly Minimum Data Set (MDS) dated 7/11/23, indicated R25 had mild cognitive impairment and diagnoses of stroke and chronic respiratory failure. Furthermore, R25's MDS indicated R25 required supplemental oxygen. R25's provider order dated 10/5/22, indicated R25 required Ipratropium-albuterol solution .5/2.5 milligrams (mg) per 3 milliters (ml) (medication to help open airways and improve breathing) via nebulizer (machine to administer inhaled medications) 4 times daily for shortness of breath. R25's provider orders lacked indication R25 was able to self-administer medications. R25's medical record lacked indication an assessment for R25 to self-administer nebulizer medications had been completed. An observation on 8/28/23 at 6:50 a.m., trained medication assistant (TMA)-A walked by R25's room stopped and opened the door slightly to peer inside before partially closing door and continuing down the hallway. An observation on 8/28/23 at 6:52 a.m., R25 was lying in bed with a nebulizer mask in place and running. The nebulizer appeared to be almost completed, however no staff were in room. At 6:57 a.m., TMA-A entered room. TMA-A waited in room until nebulizing medication was completed before removing mask from R25.	F 554	The facility continues to follow the Self Administration of Medication Policy. Each resident has a right to self-administer drugs unless the interdisciplinary team has determined for each resident that the practice is clinically inappropriate. R25 nebulizer was reviewed and he should not be left alone to Self-administer his meds. No harm came to this resident. His care plan and orders reflect he is not able to Self-administer his nebulizers. R98 had eye drops, pain balm, and headache topical in her room, SAM assessment was completed for these medications and she is able to self administer her medications. Orders and care plan have been updated to reflect these changes. The medications will be stored in the resident's room locked. The facility has reviewed all residents to ensure there are no unsecured medications in rooms that residents have not been assessed to be appropriate for Self-Administration, and the facility ensured these residents have a physician order and their care plan reflects the ability to self-administer medications. Education on Self Administration of medication was initiated with Nurses and TMAs. Random audits initiated and will be completed on 10% of residents for compliance weekly for 4 weeks. Results will be reported to the QA committee and	

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F 554	Continued From page 9 An observation on 8/29/23 at 11:56 a.m., R25 was seated in the wheelchair in his room. The nebulizer mask was on and running. R25 stated "can it come off....it is done". Staff were not present in the room. At 12:02 p.m., TMA-B entered the room and removed the nebulizer mask and asked R25 if he was ready for lunch. When interviewed on 8/28/23 at 7:23 p.m., TMA-A stated residents who want to self-administer medications require an assessment and a provider order. TMA-A verified this was true for nebulizers as well. TMA-A thought R25 had one, but acknowledged there was no order or assessment completed. TMA-A further verified they had left R25's room when administering the nebulizer to document on the computer and was not present during administration of the nebulizer. When interviewed on 8/29/23 at 12:04 p.m., TMA-B stated an order would direct if the resident could self-administer medications. TMA-B further stated R25 was not able to self-administer any medications and was dependent on staff. TMA-B acknowledged they had not remained in the room with R25 for the duration of the nebulizer medication. When interviewed on 8/29/23 at 12:09 p.m., licensed practical nurse (LPN)-B stated there needs to be an order to self-administer medications and an assessment. LPN-B verified there was an assessment for inhaled medications that had been started on 8/28/23 but was not completed. When interviewed on 8/30/23 at 10:33 a.m., the	F 554	the need for ongoing audits and actions plans initiated as appropriate. Clinical Administrator will be responsible for ongoing compliance. Date for compliance is 10/13/2023.	

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F 554	Continued From page 10 director of nursing (DON) expected staff to remain in the room when administering all medications unless the resident had an order and an assessment. R98's annual Minimum Data Set (MDS) dated 7/4/23, lacked indication of R98's cognitive status with Care Area Assessment (CAA) triggered for cognitive loss, dementia and communication. R98's face sheet printed on 8/30/23, indicated R98 diagnoses included acute and chronic respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body or when you have too much carbon dioxide in your blood), acute onset chronic diastolic heart failure (Heart failure that comes suddenly, often with sudden difficulty breathing and fatigue) and hereditary and idiopathic neuropathy unspecified (a group of inherited disorders that affect the nerves that branch out from the brain and spinal cord). R98's physician orders dated 6/2/22, indicated genteal tears solution 0.1-0.3 percent, instill one drop in both eyes as needed for dry eyes for times daily as needed (PRN); biofreeze external gel four percent topical analgesic. Apply to left shoulder topically as needed for chronic pain in shoulder. Apply thin layer daily prn until further notice. R98's care plan updated 7/15/23, indicated I am	F 554		

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F 554	Continued From page 11 not able to self administer my own medications, set up and administer per orders. R98's care plan revised 7/18/23, indicated R98 has long-term and short-term memory impairment. Primary language is Cantonese and ability to participate in brief interview for mental status (BIMS) is dependent on availability of interpreter. Has communication problem with interventions that included use of communication board and provide interpreter as necessary. During observation and interview on 08/29/23 10:46 a.m., R98 had a tube of biofreeze cream which she pulled out of her wheelchair to show surveyor while talking in preferred language, with a few words of English stating "pain" "hurt" and pointing to shoulders and legs. There was a bottle of green liquid written in an unknown language sitting outside an opened box. There were two additional unopened boxes similar to the opened box, with unknown language written on the boxes. One bottle of genteal eye drops was also noted on top of wooden drawer near bed. During observation on 8/29/23 at 11:16 a.m., registered nurse (RN)-F entered R98's room to give medications. R98's room door was opened. The unknown contents were on top of the bed side table and the genteal eye drops were on top of the wooden drawer in room. RN-F completed giving resident R98 her medications and left room. There was no observation of RN-F removing the items one bottle with green content, two unopened bottles of unknown content), genteal eye drops; these were left in R98's room. These bottles of unknown content and the genteal eye drops could be seen on top of the table and wooded drawer in clear view from the	F 554		

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F 554	Continued From page 12	F 554		

door way. R98's record lacked documentation of a self-administration assessment.

During interview on 8/29/2023 at 2:25 pm p.m., RN-F stated today was the first day observing unknown items (bottle of green liquid, two unopened boxes of unknown content, genteal eye drops) in R98's room on bed side table and on top of the wooden drawer but was not aware of a self-administration assessment for resident R98 and verified one should have been completed with eye drops and unknown items in R98's room. RN-F did not remove unknown items from R98's room. These items remained in R98's room until the end of the survey.

When interviewed on 8/29/23 at 2:49 pm p.m., licensed practical nurse (LPN)-C stated R98 had pain cream used and kept by R98. LPN-C also stated had seen what appeared like homeopathic medication brought in by family for R98 to use for her pain for rubbing on her skin. LPN-C was aware of the boxes with unknown contents being in R98's room on an ongoing basis and was aware R98 used these items. LPN-C did not know if there was a self-administration assessment completed for R98.

During interview on 8/29/23 at 3:05 p.m., registered nurse (RN)-A verified unknown items in R98's room and stated there should have been a self-administration assessment completed for R98 to have the unknown items including the genteal eye drops in her room. RN-A did not remove unknown items from R98's room. These unknown items remained in R98's room until the end of the survey.

During interview on 08/30/23 12:41 p.m., family

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F 554	Continued From page 13 member (FM)-D stated the items on the table and drawer the family brings in. FM-D also stated these topical rubs were for R98's pain and FM-D also helped R98 to apply the ointments to R98's body with massage. During interview on 08/30/23 4:17 p.m., the director of nursing (DON) stated the facility did not have a self-administration assessment completed for R98 and it should have been completed for the items R98 had kept in her room including the genteal eye drops, two unopened boxes with unknown contents, the bottle of green liquid, and biofreeze cream observed in R98's room. A policy titled Self Administration of Medication Policy revised on 11/2016, directed staff to complete a self-administration of medication assessment on all residents upon admission, annually and with significant changes. Once the assessment was completed, the interdisciplinary team will review to determine the resident was able to safely self-administer medications.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests,	F 561		10/13/23

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F 561	Continued From page 14 assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide interpreter services for 1 of 1 resident (R98) with a preferred language of Cantonese reviewed for communication. Findings include: R98's annual Minimum Data Set (MDS) dated 7/4/23, lacked indication of R98's cognitive status, for brief interview of mental status (BIMS) with Care Area Assessment (CAA) triggered for cognitive loss, dementia and communication. R98's preferred language of Cantonese. R98's face sheet printed on 8/30/23, indicated R98 diagnosis included acute and chronic respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body or when you have too much carbon	F 561	The facility has reviewed the policy pertaining to Interpretive services and this continues to reflect our current practice. The facility has an updated policy in regard to managing interpreter services for residents. R98 is Cantonese. The facility has used interpreter services with this resident in the past. The facility did post the number on the face sheet and in PCC under special instructions for all staff to be able to see. Her care plan stated she uses interpreter services. Facility provided her cue cards in Cantonese for addressing her needs and cares.	

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F 561	Continued From page 15 dioxide in your blood), acute onset chronic diastolic heart failure and hereditary (Heart failure that comes suddenly, often with sudden difficulty breathing and fatigue) and idiopathic neuropathy unspecified (a group of inherited disorders that affect the nerves that branch out from the brain and spinal cord). R98's care plan revised 7/18/23, indicated R98 had long-term and short-term memory impairment. Primary language is Cantonese and ability to participate in brief interview for mental status (BIMS) was dependent on availability of interpreter. Had communication problem with interventions that included use of communication board and provide interpreter as necessary. R98's progress notes on 7/28/2023 at 11:04 p.m., read, "resident is so upset with something which is very hard to understand. She cried talking in her own language and writer is not able to understand. Writer called her daughter to translate her concern but she was at work. Resident refused to take her PM [sic] medication with the assigned trained medication assistant (TMA) and writer tried but she refused with the writer too. Writer called the assign [sic] supervisor and she was able to give her medication." R98's progress notes dated 7/3/23, indicated BIMS 0/15, indicating cognitive impairment. Resident needs an interpreter, however, was not available. Staff interview was conducted instead. During observation on 8/29/23 11:31 a.m., registered nurse (RN)-F entered R98's room and R98 began speaking in preferred language with periods of escalation in tone as she explained in preferred language. RN-F was unable to	F 561	The facility has reviewed all other current residents to ensure all residents who have difficulty communicating due to English as a second language have been offered interpreter services and these services have been accessed and the residents plan of care has been updated to reflect this need. Education on Resident Rights and interpretive services will be provided to all staff. Audits on new admissions will be completed to ensure residents can effectively make their needs and concerns known. If interpretive services are needed, the facility will ensure staff have access to the number. Household Coordinator (and/or designee) will be responsible for ongoing compliance. Date for compliance is 10/13/2023.	

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F 561	Continued From page 16 understand what R98 was saying and stated. "yeah, yeah" "do you need help with something?" as R98 spoke preferred language. When RN-F left R98's room, RN-F explained to surveyor, was unsure what R98 was explaining but thought she was saying something about a bath she had taken, where shampoo had entered her eyes, but that RN-F had difficulty understanding what she was attempting to explain. During interview on 8/29/23 at 2:25 pm p.m., RN-F stated was unaware of any interpreter service being used for R98 and was also unaware of an interpreter service contact available in R98's record. During interview on 8/29/23 at 2:49 p.m., licensed practical nurse (LPN)-C stated R98 mostly spoke her own language although could speak a few words of English. LPN-C also statd R98 would get upset if staff had difficulty understanding what she was trying to communicate. LPN-C was unaware of R98 having an interpreter line for staff to use to help with the communication barrier between staff and R98. During interview on 8/29/23 3:05 pm p.m., household coordinator (HC)-C stated had looked in R98's medical record and could not find interpreter services contact readily accessible to staff, for use in communication with R98. During interview on 8/29/23 3:05 pm p.m., RN-A went into R98's room and verified there was no communication board or interpreter line contact in R98's room. RN-A also verified interpreter service contact was not available in R98's medical record for staff to access for help interpreting R98's preferred language.	F 561		

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F 561	Continued From page 17 During interview on 8/30/23 p.m., the director of nursing (DON) stated had heard R98 had frustrations when things have not gone well for her while communicating with staff. DON also verified the facility did not have the communication board available in R98's room or the interpreter contact line in R98's chart available for staff, and further explained, the interpreter contact should have been available for staff to call for interpretive services when R98 was having difficulty communicating with staff. Facility interpreter policy was requested but not received.	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		10/13/23

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F 583	Continued From page 18 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide privacy for 1 of 1 resident (R98), when a topical medication was administered. R98's annual Minimum Data Set (MDS) dated 7/4/23, lacked indication of a R98's cognitive status with Care Area Assessment (CAA) triggered for cognitive loss, dementia and communication. R98 required extensive assist of one staff for bed mobiity, and personal hygiene. R98's face sheet printed on 8/30/23, indicated R98 diagnosis included acute and chronic respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body or when you have too much carbon dioxide in your blood), acute onset chronic diastolic heart failure and hereditary (Heart failure that comes suddenly, often with sudden difficulty breathing and fatigue) and idiopathic neuropathy unspecified (a group of inherited disorders that affect the nerves that branch out from the brain and spinal cord).	F 583	The Dignity policy dated Dec 2014 and Resident Rights policy dated Nov 2022 were both reviewed and are current. The facility continues to promote resident rights, personal privacy, and dignity to the residents we serve. It is the policy of Presbyterian Homes and Services that residents are cared for in a manner and in an environment that promotes maintenance and/or enhancement of each resident’s quality of life. R98 remains a resident in the facility and has been assessed and has no adverse psychosocial impairment from the incident on 8/29/23. Education to all staff on the importance of privacy and closing doors to help protect resident dignity and rights. Random audits will be initiated and will be completed on 10% of residents for compliance weekly for 4 weeks to ensure	

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F 583	Continued From page 19 R98's physician orders dated 6/2/22, indicated biofreeze external gel four percent topical analgesic. Apply to left shoulder topically as needed for chronic pain in shoulder. Apply thin layer daily prn until further notice. R98's care plan revised 7/18/23, indicated R98 has long-term and short-term memory impairment. Primary language is Cantonese and ability to participate in brief interview for mental status (BIMS) is dependenat on availability of interpreter. Has communication problem with interventions that included use of communication board, and provide interpreter as necessary. R98's care plan lacked interventions to maintain R98's privacy. During observation on 08/29/23 11:16 a.m., registered nurse (RN)-F entered R98's room. RN-F was observed applying unknown cream to R98's back while room door was opened. R98 was sitting in her wheelchair, positioned sideways from room door, near bed and the side of her right breast and back could be seen from the doorway. RN-F observed surveyor looking into R98's room and then shut the door. During interview on 8/29/2023 at 2:25 p.m., RN-F stated I forgot to shut the door but I should have provided privacy for R98 while applying lotion to her back with breast and back exposed. RN-F stated I did not know R98 would lift her blouse so high up. During interview on 08/30/23 4:17 PM p.m., the director of nursing (DON) stated, it was the expectation staff provided privacy when providing personal cares for residents.	F 583	resident privacy and confidentiality. Results will be reported to the QA committee and the need for ongoing audits and actions plans initiated as appropriate. Clinical Administrator) will be responsible for ongoing compliance. Date for compliance is 10/13/2023	

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F 583	Continued From page 20 A privacy policy was requested but not received. A facility policy titled Dignity dated 12/2014, indicated it is the policy of Presbyterian Homes and Services that residents are cared for in a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life. Presbyterian Homes and Services is committed to an atmosphere that humanizes and individualizes each resident and their experiences.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		10/13/23

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F 585	Continued From page 21 of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately	F 585		

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F 585	Continued From page 22 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to initiate a grievance process to address family member (FM) concerns pertaining to level of care changes for 1 of 2 residents (R5) reviewed for grievances. Findings include: R5's quarterly Minimum Data Set (MDS) dated	F 585	The facility reviewed the Vulnerable Adult Policy, which includes the Quality Concern/Grievance Process, dated January 2023. This policy is still current & in effect. The facility practice is to ensure resident complaints are being documented and followed up on appropriately according to our policies and procedures.	

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F 585	Continued From page 23 8/11/23, indicated R5 required extensive assistance for bed mobility, transfers, dressing, eating, toileting, and personal hygiene. R5 did not ambulate in the hall or in room and had a diagnoses of non traumatic brain dysfunction, and Alzheimer's disease and received hospice care. R5's nursing progress note dated 8/22/23, indicated R5 was placed on COVID isolation from 8/1/23 to 8/10/23, due to testing positive for COVID and R5 was back to her baseline. R5's care conference summary progress note dated 8/24/23 at 6:54 a.m., indicated the household coordinator, clinical coordinator, hospice social worker (SW), R5's spouse, and R5's daughter attended the care conference and discussed R5's resource utilization group (RUG) (a system that classifies residents into distinct groups based on the resident's condition and care which determines the daily rate the facility charges for resident's care) change with having COVID. No additional information was provided whether concerns were resolved in the progress note. R5's hospice progress note dated 8/24/23 at 1:26 p.m., indicated the hospice SW attended the care conference and the main concern was finances. The SW note indicated to continue to follow concern. Grievances were reviewed from the past four months and lacked information a grievance report was completed regarding FM-A's concern. During interview on 8/27/23 at 5:21 p.m., FM-A stated R5's level of care was increased for no reason and FM-A was being billed for $641.00	F 585	R5 was reviewed and this resident did not get billed for the higher level of care due to isolation due a significant change of status being completed before the effective date of the Quarterly MDS that increased the room rate. The facility has spoken to the husband who voiced this concern, and this grievance is now resolved. The interdisciplinary team and floor staff have been re-educated regarding the grievance process. The grievance form will be filled out and properly followed up on as resident or family concerns arise. The Administrator will complete additional follow-up as needed to ensure the grievance has been resolved. Random audits will be initiated and completed on 10% of residents for compliance weekly for 4 weeks to ensure resident concerns are being addressed. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Administrator and/or designee will be responsible for ongoing compliance. Date for compliance is 10/13/2023.	

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F 585	Continued From page 24 per day adding the only thing they could think of was because R5 was in quarantine for 10 days following COVID. FM-A stated he received a letter R5's level of care was raised and added he would soon be bankrupt. FM-A stated he spoke with registered nurse (RN)-B who thought the reason was due to R5 having COVID, and did not know of any other reason that would prompt an increase. FM-A also stated a care conference was completed on 8/24/23 and the social worker (SW) was aware of the situation but did not provide any feedback. During interview on 8/30/23 at 12:10 p.m., registered nurse (RN)-B stated was aware R5's payment went up and added it happened because of COVID isolation. RN-B stated as of 8/24/23, R5 was back to the previous RUG score and added the family must not be aware of it because it was six days ago. R5's family had concerns despite having a care conference and added the review was ongoing. RN-B was not responsible for explaining the information to FM-A. RN-B stated when families bring up concerns, he tries to talk to the family right away and looks for the correct people to respond to them and added he completed grievance forms in the past, but did not complete a form regarding R5 and added the SW usually addressed concerns. During interview on 8/30/23 at 12:23 p.m., SW-A stated a care conference was completed the week prior. SW-A further stated R5's daily rate went up significantly from $396.00 to $641.00 and added when families express concerns regarding RUGS, they direct the families to complete an appeal. SW-A further stated when a resident's family or resident inform staff of a concern, she	F 585		

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F 585	Continued From page 25 completes a grievance form, identifies what the grievance is and follows up timely with the appropriate party. Once there are additional details, SW-A stated she follows up with the family and the form is turned in to the administrator. SW-A further stated they maintain a log of grievances, the date, and how the grievance was addressed, and the families reaction and identified the purpose of the grievance process was to allow family the opportunity to express concerns and the facility can follow up to assure the concern does not go un-addressed. During interview on 8/30/23 at 12:33 p.m., the administrator stated concerns were addressed right away for example nurse would start a grievance form and the household coordinator follows up timely to assure the pieces are addressed. The administrator stated she has not been notified of any grievances related to finances and further stated the household coordinator would connect the family with the biller. A policy, Quality Concern/Grievance Process dated January 2023, indicated quality concern forms were available to any resident, resident representative, visitor, staff, or vendor. the policy further indicated if a concern/grievance was filed orally the staff member receiving the information should write a brief description of the concern. The concern/grievance would be addressed minimally within five working days and action items would be communicated to the individual filing the grievance unless indicated as anonymous.	F 585		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		10/13/23

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F 690	Continued From page 26 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 690	The facility reviewed the Catheter-Care of	

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F 690	Continued From page 27 review, the facility failed to ensure appropriate management of an indwelling catheter was provided for 2 of 2 resident (R31, R6) reviewed for indwelling catheters. Findings include: R31's significant change Minimum Data Set (MDS) dated 7/13/23, indicated R31 was cognitively intact and had diagnoses of liver disease, heart failure and urine retention. Furthermore, R31's MDS indicated R31 required an indwelling catheter. R31's bladder care area assessment (CAA) dated 7/13/23, indicated. R31 had an indwelling catheter and required monitoring to reduce risks of infection. R31's provider orders revised 9/19/22, directed staff to complete catheter cares each shift and as needed. R31's care plan dated 9/20/22, indicated R31 had an indwelling catheter related to urine retention. Furthermore, R31 required catheter care per facility protocol. An observation on 8/29/23 at 9:27 a.m., nursing assistant (NA)-A entered R31's room to assist with R31's catheter. R31 was sitting on the edge of the bed and the catheter bag with yellow urine was hung on a bottom dresser drawer. R31's catheter tubing was tangled around her leg. NA-A unhooked the drainage bag and assisted with untangling the catheter. R31 stood up and NA-A helped pull the catheter bag through R31's pajama shorts and underwear as it was looped over the top. R31's catheter was not secured to her leg. NA-A hung the drainage bag back on the lower dresser drawer. NA-A left and returned	F 690	Indwelling Policy dated June 2021 and this policy is still current and in effect. It remains the practice of the facility to ensure staff provide catheter cares according to our policy and procedures. R31 remains in the facility and their plan of care and NAR sheets reflect that a catheter leg strap is to be used to secure the catheter to prevent trauma. This resident has not experienced any negative effect from not having this care planned prior to survey. R6 has an indwelling catheter a new assessment was completed to reflect this. Her care plan and care sheet were updated to reflect the changes. R6 has an anti-reflux catheter bag. Facilities practice will continue to use these bags to decrease the risk of infections. Education on indwelling catheter cares will include positioning of the catheter bag, performing catheter cares, and proper technique for cleaning the port with catheter bag emptying. Education will also include; completing assessments with changes in bowel and bladders status and updating care plan and care sheets as needed. Random audits initiated and will be completed on 10% of residents weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate.	

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F 690	Continued From page 28 with a strap to secure R31's catheter to her leg. NA-A assisted R31 getting dresses. No other catheter cares were completed. When interviewed on 8/29/23 at 9:40 a.m., R31 stated she had not had a strap to secure the catheter since right after admission. Furthermore, R31 stated I don't know why NA-A put one on now. When interviewed on 8/29/23 at 9:55 a.m., NA-A verified R31's catheter should be secured to ensure the tubing stays close and runs down. NA-A wasn't sure why it was not secured. When interviewed on 8/29/23 at 12:53 p.m., registered nurse (RN)-C stated all catheters should be secured and he wasn't sure why R31's was not. RN-C further stated it was important to prevent any harm by pulling or kinking. A facility policy titled Care of Indwelling Catheter revised 6/2021, directed staff to secure catheter tubing to the resident to prevent trauma to the urethra and to keep the drainage bag below the bladder level to prevent urine reflux into the resident's bladder. Urine reflux can cause bladder distention or infection. R6's significant change Minimum Data Set (MDS) dated 7/26/23, indicated R6 was cognitively intact, and required extensive assist of one staff for toileting and personal hygiene. R6's face sheet printed 8/30/23, indicated resident diagnosis included congestive heart failure (CHF), urinary tract infection, and atrial fibrillation.	F 690	Clinical Administrator or designee will be responsible for ongoing compliance. Date for compliance is 10/13/2023.	

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	245424	A. BUILDING _____ B. WING _____	C 08/30/2023

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F 690	Continued From page 29 R6's bladder care plan revised on 7/31/23, indicated R6 was occasionally incontinent of bowel and bladder, with goal that included would be free from skin breakdown due to incontinence and from brief use through review date. R6's catheter care plan initiated 8/27/23, had interventions that included position catheter below the level of the bladder, assess/evaluate my bowel and bladder function upon admission and quarter per policy as needed. Catheter care per facility protocol. R6's physician orders dated 8/4/23, included catheter care every shift and as needed. Document output in point of care (POC) record two times a day for catheter maintenance. Catheter bag and/or leg bag covered at all times. Catheter type: foley catheter; Size of catheter: 16 french; size of balloon 10 cubic centimeters (cc); diagnosis for catheter: comfort/hospice During observations and interview on 8/27/23, at 3:11 p.m. R6's catheter was attached to the side of her wheelchair (w/C) and not in a privacy bag. R6's catheter could be seen from the doorway. R6's catheter was attached to the side of her wheelchair (w/c), at the level of the bladder, instead of lower than R6's bladder to allow drainage into the cathteter bag and prevent back flow. During observation on 8/27/23 at 3:11 p.m., R6's catheter was attached to the side of her w/c and not in a privacy bag. R6's catheter could be seen from the doorway. R6's catheter was attached to the side of her wheelchair (w/c), at the level of the	F 690		

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F 690	Continued From page 30 bladder instead of lower than R6's bladder to allow drainage into the cathteter bag and prevent back flow. During observation on 8/29/23 at 1:09 p.m., R6's catheter was attached to the side of her W/C, hooked onto a bag attached to the top side rail attachment on W/C. R6's catheter tubing and catheter bag were at the level of her bladder. When interviewed on 8/30/23 at 10:50 a.m., nursing assistant (NA)-F verified catheter bag was not below the bladder as should have been to allow urine to drain into the bag and prevent back flow. During interview on 8/30/23 at 4:17 p.m., director of nursing (DON) stated it was the expectation catheter bags were placed below the bladder to prevent urine backing up into the bladder. Facility policy titled Catheter- Care of Indwelling Cath Policy modified on 6/2021, indicated to never raise a catheter bag above the level of the bladder. This could increase the chance of a bladder infection.	F 690		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		10/13/23

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F 757	Continued From page 31 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor side effects for 1 of 3 (R43) residents reviewed for anticoagulation (blood thinner) therapy. Findings include: R20's quarterly MDS dated 6/30/23, indicated R20 had mild cognitive impairment and diagnoses of stroke with hemiplegia (paralysis on one side). Furthermore, R20's MDS indicated R20 was on an anticoagulation medication. R20's provider order dated 6/22/21, indicated R20 required rivaroxaban 20 milligrams (mg) daily for blood clots. A review of R20's body audits from 7/6/23-8/24/23 lacked indication R20 had any bruising. R20's care plan revised 7/23/23, indicated R20 was at risk for side effects of anticoagulation use for history of blood clots and stroke. Furthermore, R20's care plan directed staff to monitor for side effects including but not limited to	F 757	The Long-term care policy and procedure manual preparation and general guidelines: IIA2: Medication administration general guidelines were reviewed and remains current and in effect. The facility continues to promote safe medication administration with appropriate side effect monitoring. Also, the Skin Integrity Management Policy revised on 9/2006 is current and in effect, which directs staff to inspect skin with cares for signs of breakdown and to perform weekly body audits and document finding per facility. R20 is taking rivaroxaban for blood clots the bruise noted has resolved, and there are no further concerns with skin or bruising with this resident. Education on side effect monitoring and completing body audits to look for bruising or skin integrity concerns will be provided for all nursing staff. Furthermore, education to both NAR and Nurse's to	

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F 757	Continued From page 32 bruising, bleeding, stroke, and heart attack. R20's nursing assistant (NA) task sheet titled Anticoagulant Use for 8/2023, indicated 8 times R20 had bruising, discoloration or bleeding that was reported to nurses. However, the follow up responses indicated R20 had no bruising. An observation on 8/27/23 at 6:42 p.m., R20 had a blueish bruise on the inside lateral aspect of her left wrist. The bruise did not appear recent and R20 was able to move her hand and wrist freely. When interviewed on 8/28/23 at 8:43 a.m., R20 was not sure of how she got the bruise on the left wrist. R20 thought it had been there a long time "maybe a month". R20 further stated maybe someone looked at it once, but not sure when. R20 further stated the bruise didn't hurt but was ugly. When interviewed on 8/29/23 at 2:28 p.m., NA-E stated if bruises were noted on a resident they would get reported right away to the nurse. NA-E acknowledged the bruise on R20 and stated it was not new and had been there for a while, so there was not a need to report it to the nurse. When interviewed on 8/29/23 at 2:47 p.m., licensed practical nurse (LPN)-A stated residents who receive anticoagulation require monitoring for bleeding and bruising. LPN-A further stated all skin alterations would require a resident occurrence form to be completed, even bruises. This brings awareness to everyone so the bruise can be monitored. LPN-A was not aware of bruising on R25's wrist. LPN-A verified there was no order to monitor or note of the bruise in the weekly body audits. LPN-A verified the bruise on	F 757	report bruising and to complete an occurrence report and chart if there are skin integrity concerns in progress note and/or body audit. Residents have weekly and as needed body audits. Facility completed full house audit of all residents on anticoagulants to ensure side effect monitoring was in place. Random audits initiated and will be completed on 10% of residents weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Clinical Administrator or designee will be responsible for ongoing compliance. Date for compliance is 10/13/2023	

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F 757	Continued From page 33 R20's wrist and stated an occurrence form was needed. When interviewed on 8/29/23 at 3:16 p.m., registered nurse (RN)-A stated all bruises should be documented even if it was known how the bruise was obtained. RN-A further stated it was important to monitor bleeding or bruising in anticoagulation medications. When interviewed on 8/3023 at 10:35 a.m. the Director of Nursing (DON) stated residents on anticoagulation require monitoring for bruising and bleeding. DON further expected all bruises to be reported with an occurrence form for monitoring. A facility policy titled Skin Integrity Management Policy revised 9/2006, directed staff to inspect skin with cares for signs of breakdown and to perform weekly body audits and document findings per facility policy.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		10/13/23

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F 812	Continued From page 34 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure foods were labeled, free from freezer burn, and the freezers were cleaned and maintained. Additionally, the facility failed to ensure use of hair restraints during food preparation and the refrigerators in the unit dining rooms were maintained. Findings include: During the initial kitchen tour with the nutrition and culinary supervisor (NCS) on 8/27/23 at 11:51 a.m., observed the following: Kitchen Freezer: 1 package of undated veggie burger patties NCS stated the patties would be tossed because they should have been dated 1 full box dated 6/19/23, contained ground hamburger patties that were open to air NCS stated the package should be closed and verified there were ice particles on the hamburger and the meet contained varied colors. Hot dogs in an undated plastic container, NCS stated she had no idea how long they had been in the freezer 1 bag of undated and opened to air corn with a best by date of 7/2025 1 package of pork cutlets NCS stated contained ice particles and was freezer burnt	F 812	The 'Food Storage Policy' dated 04/2019 was reviewed and remains in effect. The facility continues to strive to ensure that foods are properly dated, labeled, and stored. All unlabeled products were disposed of at the time of the initial kitchen tour. In the facility's fourth and second floor pantries, all undated and unlabeled containers were disposed of at the time of the survey. Education will be initiated to culinary staff on proper handling, dating, and labeling of freezer food. Staff education will be done on how to properly cover facial hair when working with food. Dry storage education will be completed on dating and labeling will be done with all cooks. Education will be followed by weekly audits of the affected areas for two months, with monthly audits to follow. The education and audits will be reviewed at the quarterly QAA meeting. Culinary Director or designee will be responsible for ongoing compliance. Date for compliance is 10/13/2023.	

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F 812	Continued From page 35	F 812		

1 opened and undated five pound bag of chick
The back of the freezer contained a build up of icicles

Dry Storage:

1 bottle of Canola with the cap unsecured and NCS stated the cap should be secured
1 plastic bottle of browning sauce with a build up on the opening NCS stated 3/27/22 was the date and the build up was dried sauce and the bottle would be tossed

Basement Freezer:

1 bag of opened bananas with ice particles and three bags of bananas with torn bags NCS stated should be thrown away
3 packages of unlabeled and undated mashed bananas
7 packages of unlabeled brown frozen items NCS stated she did not know what was in the packages, but it looked like roast beef that was discolored with snow in the bags.
The floor of the freezer contained dirty particles NCS stated she assumed was bananas.

Main Kitchen:
An unnamed male in the kitchen wore a hair net, but had a beard and was working next to food items with no coverage for the facial hair.

During interview and observation on 8/29/23 at 7:40 a.m., the refrigerator in the north dining room contained a container of undated macaroni and cheese and a plastic container that was unlabeled and undated. The culinary director (CD) stated she would pull the items.
Additionally, an undated container covered in tin

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F 812	Continued From page 36 foil contained mini donuts. A sign located on the refrigerator indicated the food was for residents and employee lunches and beverages were not to be stored in the refrigerator. The freezer contained a Dilly bar the CD stated was partially eaten and was stuck on the freezer surface and CD removed the item. During interview on 8/29/23 at 7:59 a.m., to 8:08 a.m., CD stated the bananas were disposed and stated the service representative came out on 8/28/23, and they updated him on the ice dam in the freezer and added it is something in the ceiling. CD stated expected food times to be labeled and dated. CD also stated they didn't require coverage for beards under food code. During interview and observation on 8/29/23 from 11:23 a.m. to 11:30 a.m., on the second floor refrigerator in the dining area, observed spots in the door on the second shelf from the bottom and the inside of the door hinges contained some dried spots that were caked on and NCS stated may have to put a work order in for the drippings in the refrigerator because it was caked on. During interview and observation on 8/29/23 at 11:40 a.m., on the third floor dining room refrigerator, a bottle of chocolate syrup with a brown substance located around the whole top of the container was located in the refrigerator and cook-(C)-A stated it was chocolate syrup on the lid and around the lid and would toss the item. A policy, Safe Food Storage Policy dated May 2019, indicated employees who received and stored food would maintain the storage areas including dry, refrigerated and frozen storage areas utilizing the following guidelines: make sure	F 812		

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F 812	Continued From page 37 all goods are dated with received dates, label, date and properly cover all food items upon opening of package. A policy, Labeling and Dating Policy (Ready to Eat and /or Potentially Hazardous Food) dated August 2019, indicated label and date ready to eat and or potentially hazardous foods that are opened and or prepared with the following information: clearly indicate name of product if not in original container, mark food containers to show when food was opened/prepared, or when the food must be used or discarded based on facility procedure. Foods that are not marked will be discarded.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		10/13/23

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F 880	Continued From page 38 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 39 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed during catheter cares and catheter cares were provided to minimize risk of infection for2 of 2 residents (R31, R6) observed for indwelling catheters. Furthermore, the facility failed to ensure hand hygiene was completed for 1 of 1 residents (R20) observed for incontinent cares. Findings include: Catheter cares R31's significant change Minimum Data Set (MDS) dated 7/13/23, indicated R31 was cognitively intact and had diagnoses of liver disease, heart failure and urine retention. Furthermore, R31's MDS indicated R31 required an indwelling catheter. R31's bladder care area assessment (CAA) dated 7/13/23, indicated. R31 had an indwelling catheter and required monitoring to reduce risks of infection. R31's provider orders revised 9/19/22, directed staff to complete catheter cares each shift and as needed. R31's care plan dated 9/20/22, indicated R31 had an indwelling catheter related to urine retention.	F 880	The Infection Control Policy and the Policy on Transmission Based Precautions and Hand Hygiene were reviewed and remain in effect. Johanna Shores continues to prevent the spread of infections by following the Infection control policy. It also remains the expectation for staff to follow the hand hygiene policy, provide incontinence and catheter cares, and sanitize equipment and mechanical lifts according to the Infection Control Policy. R31 remains a resident in the facility and has not experienced a negative outcome from the care received during the survey as evidenced by no CAUTI being identified. R20 remains a resident in the facility and has had no negative outcome due to the improper infection control used during observation during the survey. R6 remains a resident in the facility and has no negative outcome due to the lack of hand hygiene and infection control noted during the survey. Education on the infection Control Policy and Procedure, Hand Hygiene Policy and catheter care cleaning and dressing	

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F 880	Continued From page 40 Furthermore, R31 required catheter care per facility protocol. An observation on 8/29/23 at 9:27 a.m., nursing assistant (NA)-A entered R31's room to assist with R31's catheter. R31 performed hand hygiene and donned gloves. R31 was sitting on the edge of the bed and the catheter bag with yellow urine was hung on a bottom dresser drawer. R31's catheter tubing was tangled around her leg. NA-A unhooked the drainage bag and assisted with untangling the catheter. R31 stood up and NA-A helped pull the catheter bag through R31's pajama shorts and underwear. NA-A hung the drainage bag back on the lower dresser drawer. NA-A assisted R31 to pull off a dirty panty liner from the underwear and placed in the garbage. NA-A removed the soiled underwear and placed in a dirty laundry bin inside R31's closet. Without removing gloves or performing hand hygiene, NA-A opened R31's dresser drawer and obtained clean underwear and shorts. NA-A unhooked R31's catheter from the dresser and helped loop the catheter bag through the underwear and shorts and hung the drainage bag on the lower dresser drawer. Without removing gloves or performing hand hygiene, NA-A obtained a urinal from the bathroom and placed on the floor, and the blue tip of the catheter was opened to empty but before emptying, NA-A then secured the blue tip and went back to R31's bathroom opened the plastic package of bath wipes and obtained one. NA-A then returned and unsecured the blue catheter tip and emptied the urine into the urinal. Once empty, NA-A used the bath wipe to clean the blue catheter tip and drainage bag. The drainage bag was hung on the dresser drawer and NA-A brought the urinal was emptied in the bathroom.	F 880	changes will be completed with all staff. Random audits have been initiated and will be completed on 10% of residents regarding infection control practices and hand hygiene compliance weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Clinical Administrator, in coordination with Infection Control Nurse, will be responsible for ongoing compliance. Date certain for ongoing compliance is 10/13/2023.	

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 _____	C 08/30/2023

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 880	Continued From page 41 NA-A removed gloves and performed hand hygiene. NA-A donned gloves and assisted R31 with a new leg strap to secure the catheter tubing and to assist R31 with dressing. No other catheter cares were completed. When interviewed on 8/29/23 at 9:55 a.m., NA-A stated gloves should be removed, and hand hygiene performed after handling soiled items. NA-A acknowledged R31 was usually independent with those cares and hand hygiene and glove exchange was missed when assisting with the soiled pad and underwear. NA-A further stated alcohol wipes were used to clean the catheter tip after emptying, but NA-A did not have any in the room, so the bath wipe was used instead. Incontinent Care R20's quarterly MDS dated 6/30/23, indicated R20 had mild cognitive impairment and diagnoses of stroke with hemiplegia (paralysis on one side). Furthermore, R20's MDS indicated R20 was always incontinent of bladder. R20's care plan revised on 7/13/23, indicated R20 was incontinent of bladder and required assist of 2 staff for incontinent cares. When observed on 8/27/23 at 6:42 p.m., NA-C and NA-D entered R20's room to assist R20 back to bed. NA-C brought a lift into the room and without hand hygiene, donned gloves. NA-C and NA-D used thre lift and assisted R20 into bed. NA-C moved lift out of the way and then removed R20's shoes. NA-D turned R20 to the left side and NA-C tucked lift sling under R20 and lowered pants some to unfasten brief. R20 was then turned to the right side and NA-D removed sling	F 880		

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F 880	Continued From page 42 and placed on lift. NA-D removed R20's pants and unfastened other side of brief. NA-D then removed R20's compression stockings. NA-C tucked R20's wet brief down in between her legs and performed perianal cares. NA-D then assisted with turning R20 to the left side and NA-C removed R20's wet brief and provided perianal cares. The dirty wipes and brief were placed in the garbage. One soiled wipe remained in between R20's legs. Without glove exchange and hand hygiene, NA-C obtained a tube of barrier cream and applied to R20's bottom. NA-C removed gloves and without hand hygiene donned new gloves. R20's clean brief was placed before being turned onto her back. NA-D then removed the dirty wipe that was in between R20's leg and handed to NA-C to throw away. Without glove exchange or hand hygiene, NA-D helped fasten R20's brief and placed extra clean supplies in R20's bathroom. NA-D gathered supplies and bagged up dirty sling before removing gloves and performing hand hygiene. NA-C assisted R20 in bed then removed gloves and performed hand hygiene. When interviewed on 8/27/23 at 7:05 p.m., NA-C stated the normal process was to complete hand hygiene and use new gloves after removing the soiled brief and before moving to a clean task. NA-C acknowledged they had not used hand sanitizer when exchanging gloves and further verified this missed step was important to complete to prevent infections. When interviewed on 8/27/23 at 7:19 p.m., NA-D stated hand hygiene was needed in-between glove changes when the resident had an infection and if no infections, only a glove exchange was needed. NA-D further acknowledged handing	F 880		

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F 880	Continued From page 43 NA-C the soiled wipe that was left in between legs but was careful not to touch the resident so hand hygiene or glove exchange was not needed. R6's significant change Minimum Data Set (MDS) dated 7/26/23, indicated R6 was cognitively intact, and required extensive assist of one staff for toileting and personal hygiene. R6's face sheet printed 8/30/23, indicated resident diagnosis included congestive heart failure (CHF), urinary tract infection, and atrial fibrillation. R6's bladder care plan revised on 7/31/23, indicated R6 was occasionally incontinent of bowel and bladder, with goal that included R6 would be free from skin breakdown due to incontinence and from brief use through review date. R6's physical mobility care plan dated 8/27/23, indicated I will require assist of two with a full lift and large sling. R6's Physician order dated 7/27/23 indicated Right knee skin tear-cleanse with wound cleanser, ensure skin approximated with steri-strips, apply telfa non-stick dressing or foam dressing. Change dressing every 3 days and as needed.	F 880		

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F 880	Continued From page 44 R6's physician orders dated 8/4/23, included catheter care every shift and as needed. Document output in point of care (POC) record two times a day for catheter maintenance. Catheter bag and/or leg bag covered at all times. Hand Hygiene During observation on 8/29/23 at 2:03 p.m., resident assistant (RA)-A and RA-F entered R6's room. RA-A and RA-F assisted R6 with use of the Hoyer lift to transfer from wheelchair to bed. During transfer RA-A assisted with R6's Hoyer sling, adjusting catheter bag, adjusted R'6 feet and legs. R6's legs were wrapped in ace wraps which covered wound dressings. After transferring R6 to bed, RA-A, removed gloves, then left R6's room. RA-A did not wash hands after removing gloves. During observation on 08/30/23 at 09:56 a.m., registered nurse RN- E entered R6's room, sanitized hands, donned gloves and proceeded to remove old dressing to left leg. R6 had own dressing supplies in room and RN-E also brought into R6's room a wound care bin with wound care supplies and placed in R6's recliner with no barrier between the supplies and the w/c cushion. After removing old dressing, RN-E placed soiled dressing into garbage can. RN-E did not change gloves and grabbed a clean gauze from an opened gauze package, took a wound cleanser spray bottle and sprayed onto gauze, then used gauze to cleaned R6's left knee opened wound. RN-E then removed gloves and sanitized hands and donned gloves to continue wound care treatment.	F 880		

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F 880	Continued From page 45 During observation on 08/30/23 at 10:13 a.m., RA-F completed R6's cares while R6 was in bed. RA-F brought R6's depends near bed, RA-F then repositioned R6 away from her and completed perianal care with wet wipes. RA-F did not change gloves, touched R6's bare skin, applied lotion to R6's back, and adjusted R6's depends, blouse and pants for transfer to wheelchair. RA-F then removed gloves, sanitized hands, and donned another pair of gloves to complete R6's transfer to wheelchair. Catheter Care During observation on 8/29/23 at 2:03 p.m., RA-F took wet wipes from R6's drawer by bedside, used the wet wipes to wipe R6's foley catheter drainage bag spigot opening, and then emptied the catheter drainage bag of 200 milliliters of urine. After RA-F emptied R6's urine into a graduate cylinder, RA-F then cleansed the catheter drainage spigot opening with wet wipes before placing the drainage tubing into drain spout to secure. During observation on 08/30/23 at 9:42 a.m., RA-F took wet wipes from R6's drawer by bedside, used the wet wipes to wipe R6's foley catheter drainage bag tube opening, and then emptied the catheter drainage bag. After RA-F emptied R6's urine, RA-F then cleansed the catheter drainage tubing opening with wet wipes before placing the drainage tubing spigot into drain spout to secure. During interview on 08/30/23 at 10:47 a.m., RN-E stated should have changed my gloves after	F 880		

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F 880	Continued From page 46 removing the old, soiled dressing, and before cleaning the wound to left knee. During interview on 08/30/23 at 10:50 a.m., RA-F stated usually don't work with people with catheters often. RA-F further stated, there were no alcohol wipes in R6's room to disinfect the catheter drainage opening before emptying the catheter, so used the wet wipes instead. RN-F stated we also do use the wet wipes also for R6's perianal cares. Additionally, RA-F stated, we should change our gloves after perianal care but since R6 did not have a bowel movement and my gloves were not visibly soiled after the provided perianal care RN-F did not change gloves. When interviewed on 8/27/23 at 8:40 a.m. registered nurse (RN)-A stated hand hygiene was needed when entering rooms, in between glove changes. Furthermore, RN-A stated glove exchange and hand hygiene was required when moving from dirty areas to clean areas. When interviewed on 8/30/23 at 10:27 a.m., the Director of Nursing (DON) expected staff to complete hand hygiene with any glove removal. DON stated glove exchange with hand hygiene was needed when after handling soiled items and before handling clean items. Furthermore, DON expected staff to use alcohol wipes to clean the catheter tips as bath wipes were not appropriate as they do not remove any bacteria and this was needed to minimize risk of infection. A facility policy titled Care of Indwelling Catheter revised 6/2021, directed staff to ensure aseptic technique was used when emptying drainage bag. Fuurthermore, the policy directed staff to wipe spigot with an alcohol wipe before	F 880		

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F 880	Continued From page 47 unclamping and emptying urine. A fresh alcohol wipe was required to be used to wipe the spigot after emptied and before replaced back in the holder. A facility policy titled Infection Control Hand Hygiene dated 2020, directed staff to perform hand hygiene before perorming aseptic task and after contact with blood or body fluids. Furthermore, the policy directed staff to perform hand hygiene before gloves were donned and after gloves removed.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide air bed monitoring for safety and function for 1 or 1 resident (R6), reviewed for air bed safety. Findings include: R6's significant change Minimum Data Set (MDS) dated 7/26/23, indicated R6 was cognitively intact, and required extensive assist of one staff for bed mobility and transfers. R6's face sheet printed 8/30/23, indicated resident diagnosis included congestive heart failure (a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), urinary tract infection, and atrial fibrillation (an abnormal heartbeat).	F 908	Mattress, Bed Frame and Assistive Device Selection and Inspection Policy for Care Centers dated Nov 2022 was reviewed. R6 had their alternating air mattress replaced on 8/30/23. This resident has not had any change in condition due to the mattress light blinking as noted during the survey. An audit of all air mattresses was completed after this finding, all other air mattresses appeared to be functioning appropriately. Education on air mattresses was completed to all nursing staff, therapy,	10/13/23

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F 908	Continued From page 48 R6's skin integrity care plan updated 7/28/23, indicated R6 had a pressure relieving mattress. R6's physician orders dated 8/8/23, indicated air mattress for skin integrity. During observation on 8/29/23 at 2:03 p.m., R6 air mattress control device had a continuos blinking red light. During interview on 8/29/23 at 2:28 p.m., engineer technician (ET)-B stated if an air bed was (was-use past tense) flashing red it was probably not good and indicated a malfunction which the maintenance department would have the air bed company come into the facility to replace the air mattress with a new one. ET-B also stated the housekeeping staff had been trained to check air mattresses when the weekly bedding change was completed, as well as, daily to monitor the air bed control units. and the house keeping staff knew when something was off to notify maintenance. During observation on 08/30/23 at 8:30 a.m., R6 air mattress control device had continued with a continuous blinking red light. During interview on 08/30/23 at 08:40 a.m., the environmental director (ED)-A stated a flashing red light on the air mattresses indicated the air bed control was not working or there had been a power outage prior. ED-A stated there were no scheduled maintenance monitoring logs of air mattresses in the facility, since housekeeping and nursing checked the air mattress device once a week and notified maintenance if issues were identified. ED-A verified R6's bed had a flashing red light and was not aware of any repair request	F 908	housekeeping, and maintenance departments. Random audits initiated and will be completed on 10% of residents for compliance weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and actions plans initiated as appropriate. Clinical Administrator will be responsible for ongoing compliance. Date for compliance is 10/13/2023.	

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F 908	Continued From page 49 for R6's air mattress from housekeeping or nursing staff and could not find or provide one. Housekeeping and nursing staff air mattress education with dates completed was requested and not received. A request for air bed repair from housekeeping or nursing for R6 was requested but not received. A maintenance monitoring and inspection documentation of air beds in the facility was requested and not received. The Facility Mattress, Bed Frame and Assistive Device Selection Policy updated 11/22/23, indicated beds, mattresses, and assistive devices must be inspected following the completion of a Physical Device Assessment recommending the initiation of a device. This will occur after informed consent and risk and benefit discussion has occurred. See Physical DeviceAssessment Policy. Engineering staff will be trained on the procedure for measuring the dimensions and zones in accordance with the FDA guidelines. All other staff will be educated on observations to report. Engineering will complete an annual inspection of all beds and devices. Annual inspections will be triggered through the Presbyterian Homes and Services Tels Work Order System.	F 908		

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	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/30/2023. At the time of this survey, PRESBYTERIAN HOMES OF ARDEN HILLS was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/28/2023

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. PRESBYTERIAN HOMES OF ARDEN HILLS is a 4-story building with full basement. The building was constructed at two 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)	K 000		

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K 000	Continued From page 2 construction. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 128 beds and had a census of 125 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K 324		10/18/23

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	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2023**

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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 324	Continued From page 3 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper safety and security measures related to a cooking device in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code section 19.3.2.5.3(9). This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 08/30/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that in the following locations cooking device did not have the proper lock-out, timeout, and disconnect hardware connected to the device: 3rd Floor - Main Dining Room; 2nd Floor - South Activities Room; 1st Floor - South Activities Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	To comply with the safety and security measures for a cooking device in accordance with NFPA 101 (12) Life Safety Code section 19.3.2.5.3(9), The required Lockout, Timeout and Disconnect hardware will be connected to the cooking devices on 3rd floor-main dining room, 2nd floor-south activities room, and 1st floor-south activities room. A recurring monthly task will be added to the Electronic Work Order System to inspect and test the devices for proper operation. The Environmental Services Director will be responsible for ensuring these Lockout, Timeout, and Disconnect hardware devices are installed on or before October 13th, 2023. The Regional Engineering Manager will be responsible to add a recurring task to the Electronic Work Order System on or before October 13th, 2023. The Environmental Services Director will be responsible for ensuring this task is completed as scheduled beginning October 18th, 2023.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		10/13/23

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	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2023**

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K 353	Continued From page 4 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.1, 5.2.1.1.2(2). This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1. On 08/30/2023 between 11:00 AM and 4:00 PM, it was revealed by observation in the following locations that sprinkler heads exhibited loading and/or signs of oxidation: 4th Floor -	K 353	The facility will maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.1, 5.2.1.1.2(2). The Environmental Services Director will be responsible to ensure that the Life Safety Code requirements cited in this document will be met. 1.The fire sprinkler heads in the 4th floor serving kitchen, 3rd floor serving kitchen, and the 2nd floor serving kitchen that exhibit loading and/or corrosion will be	

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	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2023**

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K 353	Continued From page 5 Serving Kitchen; 3rd Floor - Serving Kitchen; 2nd Floor - Serving Kitchen. 2. On 08/30/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that in the 3rd Floor - 3N Mechanical Room, cabling was found attached to the Sprinkler Piping System. 3. On 08/30/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that on the 2nd Floor in the Activities Storage Closets, items were stored and stacked closer than 18 inches to the sprinkler heads 4. On 08/30/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that in the Basement Elevator Room, items were found attached and supported by the sprinkler system piping 5. On 08/30/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that in the Basement Mattress Storage Room, heating and cooling piping hangers were found attached to and presenting a load to the sprinkler system piping An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	replaced. The Environmental Services Director will be responsible for scheduling the replacement of the sprinkler heads. The replacement sprinkler heads will be installed on or before October 13th, 2023. The Environmental Services Director will ensure that the fire sprinkler system annual inspection by a qualified servicing contractor includes inspecting all heads for loading/corrosion and requires notifying the Environmental Services Director of any heads exhibiting signs of loading/corrosion so he can take the proper actions to remediate/replace. 2.The cabling that is attached to the sprinkler piping system in the 3rd floor 3N Mechanical Room will be removed by 10/13/2023. The Environmental Services Director will be responsible for ensuring the cabling is removed. The Environmental Services Director or his proxy will conduct an inspection of the sprinkler piping system throughout the building to ensure this requirement is met. This inspection will be conducted on or before 10/13/2023. 3.The items that are stacked in the 2nd floor Activities Storage Closets will be made to comply with the 18” sprinkler storage proximity requirements. The Activities employees will be in-serviced on the storage requirements pertaining to fire sprinklers. All Activities storage closets will be inspected for improperly piled items. The Environmental Services Director or his proxy will be responsible to ensure the current high piled items are	

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K 353	Continued From page 6	K 353	removed, the training of Activities staff, and the inspection of Activities storage is completed on or before 10/13/2023. 4.The items attached and supported by the sprinkler piping in the Basement Elevator Room will be removed. All elevator equipment rooms will be inspected to ensure sprinkler piping is not being used for attaching and supporting any items unrelated to the sprinkler piping. The Environmental Services Director will be responsible for ensuring the requirements are met for items attached or supported by sprinkler piping, and ensuring all elevator equipment rooms are inspected on or before 10/13/2023. 5.The heating and cooling piping hangers in the Basement Mattress Storage Room that are attached and presenting a load to the sprinkler system piping will be relocated away from the sprinkler system piping. All facility storerooms will be inspected for items that are attached to and presenting a load to the sprinkler piping system. Any violations will be rectified immediately. The Environmental Services Director will be responsible for ensuring the hangers loading the sprinkler system piping are removed and to ensure that an inspection is conducted in all other storage rooms for violations of this requirement. The date certain for this remediation and inspection is on or before 10/13/2023.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		10/13/23

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K 511	Continued From page 7 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(F), 110.27(A)(1) This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/30/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that electrical panel(s) in the following locations were found to be unsecured and readily accessible to unqualified individuals: 3rd Floor - panel L37; and 2nd Floor - panel L27 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 511	The electrical panels that were not secured in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA70 (2011 edition), National Electrical Code section 110.26(F), 110.27(A)(1) will made to comply with the requirements. The electrical panel(s) on 3rd floor-panel L37, and 2nd floor-panel L27, that were found to be unsecure and readily accessible to unqualified individuals will be made to comply with the requirements. All electrical panels in areas where unqualified persons could gain access will be inspected and made secure if necessary. All personnel who have the means to access the secure panels will be in-serviced of the necessity of ensuring the panels are resecured after the actions are complete. The Environmental Services Director will be responsible for ensuring the unsecured panels are made secure, in-servicing. the	

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K 511	Continued From page 8	K 511	required staff, and inspecting all accessible panels, are completed on or before 10/13/2023.	

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	00975	A. BUILDING: _____ B. WING _____	C 08/30/2023

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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: On 8/27/23-8/30/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued: 0835, 1080, 1375, 1540, 1565, 1805, and 1880. Please indicate in your electronic plan of	2 000		

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H54244864C (MN86894) with no licensing orders issued. 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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.	2 000		

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2 000	Continued From page 2 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. 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. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded.	2 835		10/13/23

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2 835	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate management of an indwelling catheter was provided for 2 of 2 resident (R31, R6) reviewed for indwelling catheters. Findings include: R31's significant change Minimum Data Set (MDS) dated 7/13/23, indicated R31 was cognitively intact and had diagnoses of liver disease, heart failure and urine retention. Furthermore, R31's MDS indicated R31 required an indwelling catheter. R31's bladder care area assessment (CAA) dated 7/13/23, indicated. R31 had an indwelling catheter and required monitoring to reduce risks of infection. R31's provider orders revised 9/19/22, directed staff to complete catheter cares each shift and as needed. R31's care plan dated 9/20/22, indicated R31 had an indwelling catheter related to urine retention. Furthermore, R31 required catheter care per facility protocol. An observation on 8/29/23 at 9:27 a.m., nursing assistant (NA)-A entered R31's room to assist with R31's catheter. R31 was sitting on the edge of the bed and the catheter bag with yellow urine was hung on a bottom dresser drawer. R31's catheter tubing was tangled around her leg. NA-A unhooked the drainage bag and assisted with untangling the catheter. R31 stood up and NA-A helped pull the catheter bag through R31's	2 835	corrected	

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2 835	Continued From page 4 pajama shorts and underwear as it was looped over the top. R31's catheter was not secured to her leg. NA-A hung the drainage bag back on the lower dresser drawer. NA-A left and returned with a strap to secure R31's catheter to her leg. NA-A assisted R31 getting dresses. No other catheter cares were completed. When interviewed on 8/29/23 at 9:40 a.m., R31 stated she had not had a strap to secure the catheter since right after admission. Furthermore, R31 stated I don't know why NA-A put one on now. When interviewed on 8/29/23 at 9:55 a.m., NA-A verified R31's catheter should be secured to ensure the tubing stays close and runs down. NA-A wasn't sure why it was not secured. When interviewed on 8/29/23 at 12:53 p.m., registered nurse (RN)-C stated all catheters should be secured and he wasn't sure why R31's was not. RN-C further stated it was important to prevent any harm by pulling or kinking. A facility policy titled Care of Indwelling Catheter revised 6/2021, directed staff to secure catheter tubing to the resident to prevent trauma to the urethra and to keep the drainage bag below the bladder level to prevent urine reflux into the resident's bladder. Urine reflux can cause bladder distention or infection. R6's significant change Minimum Data Set (MDS) dated 7/26/23, indicated R6 was cognitively intact, and required extensive assist of one staff for toileting and personal hygiene. R6's face sheet printed 8/30/23, indicated resident diagnosis included congestive heart	2 835		

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2 835	Continued From page 5 failure (CHF), urinary tract infection, and atrial fibrillation. R6's bladder care plan revised on 7/31/23, indicated R6 was occasionally incontinent of bowel and bladder, with goal that included would be free from skin breakdown due to incontinence and from brief use through review date. R6's catheter care plan initiated 8/27/23, had interventions that included position catheter below the level of the bladder, assess/evaluate my bowel and bladder function upon admission and quarter per policy as needed. Catheter care per facility protocol. R6's physician orders dated 8/4/23, included catheter care every shift and as needed. Document output in point of care (POC) record two times a day for catheter maintenance. Catheter bag and/or leg bag covered at all times. Catheter type: foley catheter; Size of catheter: 16 french; size of balloon 10 cubic centimeters (cc); diagnosis for catheter: comfort/hospice During observations and interview on 8/27/23, at 3:11 p.m. R6's catheter was attached to the side of her wheelchair (w/C) and not in a privacy bag. R6's catheter could be seen from the doorway. R6's catheter was attached to the side of her wheelchair (w/c), at the level of the bladder, instead of lower than R6's bladder to allow drainage into the cathteter bag and prevent back flow. During observation on 8/27/23 at 3:11 p.m., R6's catheter was attached to the side of her w/c and not in a privacy bag. R6's catheter could be seen from the doorway. R6's catheter was attached to	2 835		

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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
2 835	Continued From page 6 the side of her wheelchair (w/c), at the level of the bladder instead of lower than R6's bladder to allow drainage into the cathteter bag and prevent back flow. During observation on 8/29/23 at 1:09 p.m., R6's catheter was attached to the side of her W/C, hooked onto a bag attached to the top side rail attachment on W/C. R6's catheter tubing and catheter bag were at the level of her bladder. When interviewed on 8/30/23 at 10:50 a.m., nursing assistant (NA)-F verified catheter bag was not below the bladder as should have been to allow urine to drain into the bag and prevent back flow. During interview on 8/30/23 at 4:17 p.m., director of nursing (DON) stated it was the expectation catheter bags were placed below the bladder to prevent urine backing up into the bladder. Facility policy titled Catheter- Care of Indwelling Cath Policy modified on 6/2021, indicated to never raise a catheter bag above the level of the bladder. This could increase the chance of a bladder infection. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policies, procedures related to catheter care and educate staff. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented.. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring.	2 835		

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2 835	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) day	2 835		
21080	MN Rule 4658.0650 Subp. 1 Food Supplies; Clean,free from spoilage Subpart 1. Food. All food must be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. Canned or preserved food which has been processed in a place other than a commercial food-processing establishment is prohibited for use by nursing homes. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure foods were labeled, free from freezer burn, and the freezers were cleaned and maintained. Additionally, the facility failed to ensure use of hair restraints during food preparation and the refrigerators in the unit dining rooms were maintained. Findings include: During the initial kitchen tour with the nutrition and culinary supervisor (NCS) on 8/27/23 at 11:51 a.m., observed the following: Kitchen Freezer: 1 package of undated veggie burger patties NCS stated the patties would be tossed because they should have been dated 1 full box dated 6/19/23, contained ground hamburger patties that were open to air NCS stated the package should be closed and verified	21080	corrected	10/13/23

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21080	Continued From page 8 there were ice particles on the hamburger and the meet contained varied colors. Hot dogs in an undated plastic container, NCS stated she had no idea how long they had been in the freezer 1 bag of undated and opened to air corn with a best by date of 7/2025 1 package of pork cutlets NCS stated contained ice particles and was freezer burnt 1 opened and undated five pound bag of chick The back of the freezer contained a build up of icicles Dry Storage: 1 bottle of Canola with the cap unsecured and NCS stated the cap should be secured 1 plastic bottle of browning sauce with a build up on the opening NCS stated 3/27/22 was the date and the build up was dried sauce and the bottle would be tossed Basement Freezer: 1 bag of opened bananas with ice particles and three bags of bananas with torn bags NCS stated should be thrown away 3 packages of unlabeled and undated mashed bananas 7 packages of unlabeled brown frozen items NCS stated she did not know what was in the packages, but it looked like roast beef that was discolored with snow in the bags. The floor of the freezer contained dirty particles NCS stated she assumed was bananas. Main Kitchen: An unnamed male in the kitchen wore a hair net, but had a beard and was working next to food items with no coverage for the facial hair.	21080		

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21080	Continued From page 9 During interview and observation on 8/29/23 at 7:40 a.m., the refrigerator in the north dining room contained a container of undated macaroni and cheese and a plastic container that was unlabeled and undated. The culinary director (CD) stated she would pull the items. Additionally, an undated container covered in tin foil contained mini donuts. A sign located on the refrigerator indicated the food was for residents and employee lunches and beverages were not to be stored in the refrigerator. The freezer contained a Dilly bar the CD stated was partially eaten and was stuck on the freezer surface and CD removed the item. During interview on 8/29/23 at 7:59 a.m., to 8:08 a.m., CD stated the bananas were disposed and stated the service representative came out on 8/28/23, and they updated him on the ice dam in the freezer and added it is something in the ceiling. CD stated expected food times to be labeled and dated. CD also stated they didn't require coverage for beards under food code. During interview and observation on 8/29/23 from 11:23 a.m. to 11:30 a.m., on the second floor refrigerator in the dining area, observed spots in the door on the second shelf from the bottom and the inside of the door hinges contained some dried spots that were caked on and NCS stated may have to put a work order in for the drippings in the refrigerator because it was caked on. During interview and observation on 8/29/23 at 11:40 a.m., on the third floor dining room refrigerator, a bottle of chocolate syrup with a brown substance located around the whole top of the container was located in the refrigerator and cook-(C)-A stated it was chocolate syrup on the	21080		

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21080	Continued From page 10 lid and around the lid and would toss the item. A policy, Safe Food Storage Policy dated May 2019, indicated employees who received and stored food would maintain the storage areas including dry, refrigerated and frozen storage areas utilizing the following guidelines: make sure all goods are dated with received dates, label, date and properly cover all food items upon opening of package. A policy, Labeling and Dating Policy (Ready to Eat and /or Potentially Hazardous Food) dated August 2019, indicated label and date ready to eat and or potentially hazardous foods that are opened and or prepared with the following information: clearly indicate name of product if not in original container, mark food containers to show when food was opened/prepared, or when the food must be used or discarded based on facility procedure. Foods that are not marked will be discarded. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate sanitation and food storage occurs of food items. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21080		

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21375	Continued From page 11	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed during catheter cares and catheter cares were provided to minimize risk of infection for2 of 2 residents (R31, R6) observed for indwelling catheters. Furthermore, the facility failed to ensure hand hygiene was completed for 1 of 1 residents (R20) observed for incontinent cares. Findings include: Catheter cares R31's significant change Minimum Data Set (MDS) dated 7/13/23, indicated R31 was cognitively intact and had diagnoses of liver disease, heart failure and urine retention. Furthermore, R31's MDS indicated R31 required an indwelling catheter. R31's bladder care area assessment (CAA) dated 7/13/23, indicated. R31 had an indwelling catheter and required monitoring to reduce risks of infection. R31's provider orders revised 9/19/22, directed staff to complete catheter cares each shift and as	21375	corrected	10/13/23

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21375	Continued From page 12 needed. R31's care plan dated 9/20/22, indicated R31 had an indwelling catheter related to urine retention. Furthermore, R31 required catheter care per facility protocol. An observation on 8/29/23 at 9:27 a.m., nursing assistant (NA)-A entered R31's room to assist with R31's catheter. R31 performed hand hygiene and donned gloves. R31 was sitting on the edge of the bed and the catheter bag with yellow urine was hung on a bottom dresser drawer. R31's catheter tubing was tangled around her leg. NA-A unhooked the drainage bag and assisted with untangling the catheter. R31 stood up and NA-A helped pull the catheter bag through R31's pajama shorts and underwear. NA-A hung the drainage bag back on the lower dresser drawer. NA-A assisted R31 to pull off a dirty panty liner from the underwear and placed in the garbage. NA-A removed the soiled underwear and placed in a dirty laundry bin inside R31's closet. Without removing gloves or performing hand hygiene, NA-A opened R31's dresser drawer and obtained clean underwear and shorts. NA-A unhooked R31's catheter from the dresser and helped loop the catheter bag through the underwear and shorts and hung the drainage bag on the lower dresser drawer. Without removing gloves or performing hand hygiene, NA-A obtained a urinal from the bathroom and placed on the floor, and the blue tip of the catheter was opened to empty but before emptying, NA-A then secured the blue tip and went back to R31's bathroom opened the plastic package of bath wipes and obtained one. NA-A then returned and unsecured the blue catheter tip and emptied the urine into the urinal. Once empty, NA-A used the bath wipe to clean the blue	21375		

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21375	Continued From page 13 catheter tip and drainage bag. The drainage bag was hung on the dresser drawer and NA-A brought the urinal was emptied in the bathroom. NA-A removed gloves and performed hand hygiene. NA-A donned gloves and assisted R31 with a new leg strap to secure the catheter tubing and to assist R31 with dressing. No other catheter cares were completed. When interviewed on 8/29/23 at 9:55 a.m., NA-A stated gloves should be removed, and hand hygiene performed after handling soiled items. NA-A acknowledged R31 was usually independent with those cares and hand hygiene and glove exchange was missed when assisting with the soiled pad and underwear. NA-A further stated alcohol wipes were used to clean the catheter tip after emptying, but NA-A did not have any in the room, so the bath wipe was used instead. Incontinent Care R20's quarterly MDS dated 6/30/23, indicated R20 had mild cognitive impairment and diagnoses of stroke with hemiplegia (paralysis on one side). Furthermore, R20's MDS indicated R20 was always incontinent of bladder. R20's care plan revised on 7/13/23, indicated R20 was incontinent of bladder and required assist of 2 staff for incontinent cares. When observed on 8/27/23 at 6:42 p.m., NA-C and NA-D entered R20's room to assist R20 back to bed. NA-C brought a lift into the room and without hand hygiene, donned gloves. NA-C and NA-D used thre lift and assisted R20 into bed. NA-C moved lift out of the way and then removed R20's shoes. NA-D turned R20 to the left side and NA-C tucked lift sling under R20 and lowered	21375		

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21375	Continued From page 14 pants some to unfasten brief. R20 was then turned to the right side and NA-D removed sling and placed on lift. NA-D removed R20's pants and unfastened other side of brief. NA-D then removed R20's compression stockings. NA-C tucked R20's wet brief down in between her legs and performed perianal cares. NA-D then assisted with turning R20 to the left side and NA-C removed R20's wet brief and provided perianal cares. The dirty wipes and brief were placed in the garbage. One soiled wipe remained in between R20's legs. Without glove exchange and hand hygiene, NA-C obtained a tube of barrier cream and applied to R20's bottom. NA-C removed gloves and without hand hygiene donned new gloves. R20's clean brief was placed before being turned onto her back. NA-D then removed the dirty wipe that was in between R20's leg and handed to NA-C to throw away. Without glove exchange or hand hygiene, NA-D helped fasten R20's brief and placed extra clean supplies in R20's bathroom. NA-D gathered supplies and bagged up dirty sling before removing gloves and performing hand hygiene. NA-C assisted R20 in bed then removed gloves and performed hand hygiene. When interviewed on 8/27/23 at 7:05 p.m., NA-C stated the normal process was to complete hand hygiene and use new gloves after removing the soiled brief and before moving to a clean task. NA-C acknowledged they had not used hand sanitizer when exchanging gloves and further verified this missed step was important to complete to prevent infections. When interviewed on 8/27/23 at 7:19 p.m., NA-D stated hand hygiene was needed in-between glove changes when the resident had an infection and if no infections, only a glove exchange was	21375		

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21375	Continued From page 15 needed. NA-D further acknowledged handing NA-C the soiled wipe that was left in between legs but was careful not to touch the resident so hand hygiene or glove exchange was not needed. R6's significant change Minimum Data Set (MDS) dated 7/26/23, indicated R6 was cognitively intact, and required extensive assist of one staff for toileting and personal hygiene. R6's face sheet printed 8/30/23, indicated resident diagnosis included congestive heart failure (CHF), urinary tract infection, and atrial fibrillation. R6's bladder care plan revised on 7/31/23, indicated R6 was occasionally incontinent of bowel and bladder, with goal that included R6 would be free from skin breakdown due to incontinence and from brief use through review date. R6's physical mobility care plan dated 8/27/23, indicated I will require assist of two with a full lift and large sling. R6's Physician order dated 7/27/23 indicated Right knee skin tear-cleanse with wound cleanser, ensure skin approximated with steri-strips, apply telfa non-stick dressing or foam dressing. Change dressing every 3 days and as needed. R6's physician orders dated 8/4/23, included catheter care every shift and as needed. Document output in point of care (POC) record two times a day for catheter maintenance. Catheter bag and/or leg bag covered at all times. Hand Hygiene	21375		

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21375	Continued From page 16 During observation on 8/29/23 at 2:03 p.m., resident assistant (RA)-A and RA-F entered R6's room. RA-A and RA-F assisted R6 with use of the Hoyer lift to transfer from wheelchair to bed. During transfer RA-A assisted with R6's Hoyer sling, adjusting catheter bag, adjusted R'6 feet and legs. R6's legs were wrapped in ace wraps which covered wound dressings. After transferring R6 to bed, RA-A, removed gloves, then left R6's room. RA-A did not wash hands after removing gloves. During observation on 08/30/23 at 09:56 a.m., registered nurse RN- E entered R6's room, sanitized hands, donned gloves and proceeded to remove old dressing to left leg. R6 had own dressing supplies in room and RN-E also brought into R6's room a wound care bin with wound care supplies and placed in R6's recliner with no barrier between the supplies and the w/c cushion. After removing old dressing, RN-E placed soiled dressing into garbage can. RN-E did not change gloves and grabbed a clean gauze from an opened gauze package, took a wound cleanser spray bottle and sprayed onto gauze, then used gauze to cleaned R6's left knee opened wound. RN-E then removed gloves and sanitized hands and donned gloves to continue wound care treatment. During observation on 08/30/23 at 10:13 a.m., RA-F completed R6's cares while R6 was in bed. RA-F brought R6's depends near bed, RA-F then repositioned R6 away from her and completed perianal care with wet wipes. RA-F did not change gloves, touched R6's bare skin, applied lotion to R6's back, and adjusted R6's depends, blouse and pants for transfer to wheelchair. RA-F then removed gloves, sanitized hands, and	21375		

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21375	Continued From page 17 donned another pair of gloves to complete R6's transfer to wheelchair. Catheter Care During observation on 8/29/23 at 2:03 p.m., RA-F took wet wipes from R6's drawer by bedside, used the wet wipes to wipe R6's foley catheter drainage bag spigot opening, and then emptied the catheter drainage bag of 200 milliliters of urine. After RA-F emptied R6's urine into a graduate cylinder, RA-F then cleansed the catheter drainage spigot opening with wet wipes before placing the drainage tubing into drain spout to secure. During observation on 08/30/23 at 9:42 a.m., RA-F took wet wipes from R6's drawer by bedside, used the wet wipes to wipe R6's foley catheter drainage bag tube opening, and then emptied the catheter drainage bag. After RA-F emptied R6's urine, RA-F then cleansed the catheter drainage tubing opening with wet wipes before placing the drainage tubing spigot into drain spout to secure. During interview on 08/30/23 at 10:47 a.m., RN-E stated should have changed my gloves after removing the old, soiled dressing, and before cleaning the wound to left knee. During interview on 08/30/23 at 10:50 a.m., RA-F stated usually don't work with people with catheters often. RA-F further stated, there were no alcohol wipes in R6's room to disinfect the catheter drainage opening before emptying the catheter, so used the wet wipes instead. RN-F stated we also do use the wet wipes also for R6's	21375		

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21375	Continued From page 18 perianal cares. Additionally, RA-F stated, we should change our gloves after perianal care but since R6 did not have a bowel movement and my gloves were not visibly soiled after the provided perianal care RN-F did not change gloves. When interviewed on 8/27/23 at 8:40 a.m. registered nurse (RN)-A stated hand hygiene was needed when entering rooms, in between glove changes. Furthermore, RN-A stated glove exchange and hand hygiene was required when moving from dirty areas to clean areas. When interviewed on 8/30/23 at 10:27 a.m., the Director of Nursing (DON) expected staff to complete hand hygiene with any glove removal. DON stated glove exchange with hand hygiene was needed when after handling soiled items and before handling clean items. Furthermore, DON expected staff to use alcohol wipes to clean the catheter tips as bath wipes were not appropriate as they do not remove any bacteria and this was needed to minimize risk of infection. A facility policy titled Care of Indwelling Catheter revised 6/2021, directed staff to ensure aseptic technique was used when emptying drainage bag. Fuurthermore, the policy directed staff to wipe spigot with an alcohol wipe before unclamping and emptying urine. A fresh alcohol wipe was required to be used to wipe the spigot after emptied and before replaced back in the holder. A facility policy titled Infection Control Hand Hygiene dated 2020, directed staff to perform hand hygiene before perorming aseptic task and after contact with blood or body fluids. Furthermore, the policy directed staff to perform hand hygiene before gloves were donned and	21375		

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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
21375	Continued From page 19 after gloves removed. SUGGESTED METHOD OF CORRECTION: The DON or designee could train staff and perform audits to ensure infection hand hygiene and infection control techniques are being followed. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		10/13/23

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21540	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to monitor side effects for 1 of 3 (R43) residents reviewed for anticoagulation (blood thinner) therapy. Findings include: R20's quarterly MDS dated 6/30/23, indicated R20 had mild cognitive impairment and diagnoses of stroke with hemiplegia (paralysis on one side). Furthermore, R20's MDS indicated R20 was on an anticoagulation medication. R20's provider order dated 6/22/21, indicated R20 required rivaroxaban 20 milligrams (mg) daily for blood clots. A review of R20's body audits from 7/6/23-8/24/23 lacked indication R20 had any bruising. R20's care plan revised 7/23/23, indicated R20 was at risk for side effects of anticoagulation use for history of blood clots and stroke. Furthermore, R20's care plan directed staff to monitor for side effects including but not limited to bruising, bleeding, stroke, and heart attack. R20's nursing assistant (NA) task sheet titled Anticoagulant Use for 8/2023, indicated 8 times R20 had bruising, discoloration or bleeding that was reported to nurses. However, the follow up responses indicated R20 had no bruising. An observation on 8/27/23 at 6:42 p.m., R20 had a blueish bruise on the inside lateral aspect of her left wrist. The bruise did not appear recent and R20 was able to move her hand and wrist freely. When interviewed on 8/28/23 at 8:43 a.m., R20	21540	corrected	

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21540	Continued From page 21 was not sure of how she got the bruise on the left wrist. R20 thought it had been there a long time "maybe a month". R20 further stated maybe someone looked at it once, but not sure when. R20 further stated the bruise didn't hurt but was ugly. When interviewed on 8/29/23 at 2:28 p.m., NA-E stated if bruises were noted on a resident they would get reported right away to the nurse. NA-E acknowledged the bruise on R20 and stated it was not new and had been there for a while, so there was not a need to report it to the nurse. When interviewed on 8/29/23 at 2:47 p.m., licensed practical nurse (LPN)-A stated residents who receive anticoagulation require monitoring for bleeding and bruising. LPN-A further stated all skin alterations would require a resident occurrence form to be completed, even bruises. This brings awareness to everyone so the bruise can be monitored. LPN-A was not aware of bruising on R25's wrist. LPN-A verified there was no order to monitor or note of the bruise in the weekly body audits. LPN-A verified the bruise on R20's wrist and stated an occurrence form was needed. When interviewed on 8/29/23 at 3:16 p.m., registered nurse (RN)-A stated all bruises should be documented even if it was known how the bruise was obtained. RN-A further stated it was important to monitor bleeding or bruising in anticoagulation medications. When interviewed on 8/3023 at 10:35 a.m. the Director of Nursing (DON) stated residents on anticoagulation require monitoring for bruising and bleeding. DON further expected all bruises to be reported with an occurrence form for	21540		

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21540	Continued From page 22 monitoring. A facility policy titled Skin Integrity Management Policy revised 9/2006, directed staff to inspect skin with cares for signs of breakdown and to perform weekly body audits and document findings per facility policy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication side effects and monitoring. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R25, R98) had been assessed to safely self-administer medications. Findings include:	21565	corrected	10/13/23

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21565	Continued From page 23 R25's quarterly Minimum Data Set (MDS) dated 7/11/23, indicated R25 had mild cognitive impairment and diagnoses of stroke and chronic respiratory failure. Furthermore, R25's MDS indicated R25 required supplemental oxygen. R25's provider order dated 10/5/22, indicated R25 required Ipratropium-albuterol solution .5/2.5 milligrams (mg) per 3 milliters (ml) (medication to help open airways and improve breathing) via nebulizer (machine to administer inhaled medications) 4 times daily for shortness of breath. R25's provider orders lacked indication R25 was able to self-administer medications. R25's medical record lacked indication an assessment for R25 to self-administer nebulizer medications had been completed. An observation on 8/28/23 at 6:50 a.m., trained medication assistant (TMA)-A walked by R25's room stopped and opened the door slightly to peer inside before partially closing door and continuing down the hallway. An observation on 8/28/23 at 6:52 a.m., R25 was lying in bed with a nebulizer mask in place and running. The nebulizer appeared to be almost completed, however no staff were in room. At 6:57 a.m., TMA-A entered room. TMA-A waited in room until nebulizing medication was completed before removing mask from R25. An observation on 8/29/23 at 11:56 a.m., R25 was seated in the wheelchair in his room. The nebulizer mask was on and running. R25 stated "can it come off....it is done". Staff were not present in the room. At 12:02 p.m., TMA-B entered the room and removed the nebulizer	21565		

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21565	Continued From page 24 mask and asked R25 if he was ready for lunch. When interviewed on 8/28/23 at 7:23 p.m., TMA-A stated residents who want to self-administer medications require an assessment and a provider order. TMA-A verified this was true for nebulizers as well. TMA-A thought R25 had one, but acknowledged there was no order or assessment completed. TMA-A further verified they had left R25's room when administering the nebulizer to document on the computer and was not present during administration of the nebulizer. When interviewed on 8/29/23 at 12:04 p.m., TMA-B stated an order would direct if the resident could self-administer medications. TMA-B further stated R25 was not able to self-administer any medications and was dependent on staff. TMA-B acknowledged they had not remained in the room with R25 for the duration of the nebulizer medication. When interviewed on 8/29/23 at 12:09 p.m., licensed practical nurse (LPN)-B stated there needs to be an order to self-administer medications and an assessment. LPN-B verified there was an assessment for inhaled medications that had been started on 8/28/23 but was not completed. When interviewed on 8/30/23 at 10:33 a.m., the director of nursing (DON) expected staff to remain in the room when administering all medications unless the resident had an order and an assessment. R98's annual Minimum Data Set (MDS) dated 7/4/23, lacked indication of R98's cognitive status with Care Area Assessment (CAA) triggered for	21565		

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21565	Continued From page 25 cognitive loss, dementia and communication. R98's face sheet printed on 8/30/23, indicated R98 diagnoses included acute and chronic respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body or when you have too much carbon dioxide in your blood), acute onset chronic diastolic heart failure (Heart failure that comes suddenly, often with sudden difficulty breathing and fatigue) and hereditary and idiopathic neuropathy unspecified (a group of inherited disorders that affect the nerves that branch out from the brain and spinal cord). R98's physician orders dated 6/2/22, indicated genteal tears solution 0.1-0.3 percent, instill one drop in both eyes as needed for dry eyes for times daily as needed (PRN); biofreeze external gel four percent topical analgesic. Apply to left shoulder topically as needed for chronic pain in shoulder. Apply thin layer daily prn until further notice. R98's care plan updated 7/15/23, indicated I am not able to self administer my own medications, set up and administer per orders. R98's care plan revised 7/18/23, indicated R98 has long-term and short-term memory impairment. Primary language is Cantonese and ability to participate in brief interview for mental status (BIMS) is dependent on availability of interpreter. Has communication problem with interventions that included use of communication board and provide interpreter as necessary. During observation and interview on 08/29/23 10:46 a.m., R98 had a tube of biofreeze cream which she pulled out of her wheelchair to show	21565		

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21565	Continued From page 26 surveyor while talking in preferred language, with a few words of English stating "pain" "hurt" and pointing to shoulders and legs. There was a bottle of green liquid written in an unknown language sitting outside an opened box. There were two additional unopened boxes similar to the opened box, with unknown language written on the boxes. One bottle of genteal eye drops was also noted on top of wooden drawer near bed. During observation on 8/29/23 at 11:16 a.m., registered nurse (RN)-F entered R98's room to give medications. R98's room door was opened. The unknown contents were on top of the bed side table and the genteal eye drops were on top of the wooden drawer in room. RN-F completed giving resident R98 her medications and left room. There was no observation of RN-F removing the items one bottle with green content, two unopened bottles of unknown content), genteal eye drops; these were left in R98's room. These bottles of unknown content and the genteal eye drops could be seen on top of the table and wooded drawer in clear view from the door way. R98's record lacked documentation of a self-administration assessment. During interview on 8/29/2023 at 2:25 pm p.m., RN-F stated today was the first day observing unknown items (bottle of green liquid, two unopened boxes of unknown content, genteal eye drops) in R98's room on bed side table and on top of the wooden drawer but was not aware of a self-administration assessment for resident R98 and verified one should have been completed with eye drops and unknown items in R98's room. RN-F did not remove unknown items from R98's room. These items remained in R98's room until the end of the survey.	21565		

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21565	Continued From page 27 When interviewed on 8/29/23 at 2:49 pm p.m., licensed practical nurse (LPN)-C stated R98 had pain cream used and kept by R98. LPN-C also stated had seen what appeared like homeopathic medication brought in by family for R98 to use for her pain for rubbing on her skin. LPN-C was aware of the boxes with unknown contents being in R98's room on an ongoing basis and was aware R98 used these items. LPN-C did not know if there was a self-administration assessment completed for R98. During interview on 8/29/23 at 3:05 p.m., registered nurse (RN)-A verified unknown items in R98's room and stated there should have been a self-administration assessment completed for R98 to have the unknown items including the genteal eye drops in her room. RN-A did not remove unknown items from R98's room. These unknown items remained in R98's room until the end of the survey. During interview on 08/30/23 12:41 p.m., family member (FM)-D stated the items on the table and drawer the family brings in. FM-D also stated these topical rubs were for R98's pain and FM-D also helped R98 to apply the ointments to R98's body with massage. During interview on 08/30/23 4:17 p.m., the director of nursing (DON) stated the facility did not have a self-administration assessment completed for R98 and it should have been completed for the items R98 had kept in her room including the genteal eye drops, two unopened boxes with unknown contents, the bottle of green liquid, and biofreeze cream observed in R98's room. A policy titled Self Administration of Medication	21565		

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21565	Continued From page 28 Policy revised on 11/2016, directed staff to complete a self-administration of medication assessment on all residents upon admission, annually and with significant changes. Once the assessment was completed, the interdisciplinary team will review to determine the resident was able to safely self-administer medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed to ensure ability to safely self-administer medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 2 of 2 residents (R6, R8) reviewed for dignity. Findings include:	21805	corrected	10/13/23

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21805	Continued From page 29 R8's annual Minimum Data Set (MDS) dated 6/21/23, indicated R8 had severe cognitive impairment, did not reject care and it was somewhat important to choose what clothes to wear, was totally dependent on staff for personal hygiene to include shaving. R8's diagnoses included: non traumatic brain dysfunction, unspecified dementia, diabetes mellitus, depression, and hemiplegia or hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). R8's care plan dated 6/27/23, indicated R8 wanted to be clean and well dressed daily. Further, R8 wore a wig that was to be on in the a.m., and off at bedtime, and required two staff participation with personal hygiene and oral care. Additionally, R8 had physical behaviors of striking out, hitting and scratching staff during cares due to dementia and depression with interventions included to allow R8 to make choices when possible about cares and activities, and document observed behavior and attempted interventions per policy. Further, indicated R8 had an alteration in blood glucose related to a diagnoses of diabetes and with an intervention of a nurse would provide nail care. The care plan lacked an intervention for shaving. R8's care sheet undated, indicated R8 wore a wig during the day and was removed at bedtime, received a bath on Monday a.m., was on bleeding and bruising precautions due to being on a blood thinning medication, and the nurse was to trim nails due to a diagnosis of diabetes. The care sheet lacked instruction for staff to remove R8's facial hair. R8's Target Behavior form from 8/1/23 to 8/30/23,	21805		

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21805	Continued From page 30 indicated behaviors occurred on 8/7/23, 8/12/23, 8/13/23, and 8/26/23. The rest of the time frame indicated behaviors were documented as "did not occur" 55 times or "not applicable" 25 times. R8's Bath form from 8/1/23, to 8/30/23, indicated R8 received a bath on 8/14/23. No additional baths were documented during the time frame. Additionally, there were no documented refusals. R8's clinical physician orders dated 1/9/23, was reviewed and included an order to trim finger nails during shift every Monday and ask for nursing assistant (NA) assistance as needed. The Clinical Physician Orders form was reviewed and lacked any instruction for removing R8's facial hair. R8's medication administration record (MAR) and treatment administration record (TAR) for August 2023, was reviewed and lacked instruction for removing R8's facial hair. During observation on 8/27/23 at 3:45 p.m., R8 was observed to have a dark mustache on her upper lip and around her mouth. During observation on 8/29/23 at 7:16 a.m., R8 was up in her wheelchair and observed R8 to have a dark mustache. During observation on 8/30/23 at 8:31 a.m., R8 was at the dining room table and had a visible dark mustache noted and R8 was wearing her black colored wig. During interview 8/29/23 at 9:42 a.m., nursing assistant (NA)-B stated they looked at care sheets in order to know what kind of cares a resident required.	21805		

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21805	Continued From page 31 During interview on 8/29/23 at 9:54 a.m., NA-B stated she did not shave R8 because a nurse needed to shave R8 because she could not risk cutting R8. During interview on 8/30/23 at 9:13 a.m., registered nurse (RN)-D stated she looked to the care plan to know what kind of cares a resident received and stated women were shaved on their bath day and added if a resident was diabetic, the nurse completed shaving. After asking about R8's bath day, RN-D stated it had been a while and if the resident had an electric razor, the NA could shave the resident and stated R8 had an electric razor and therefore the aide was responsible for shaving R8. LPN-A stated when someone refused cares, it was documented. During interview and observation on 8/30/23 at 9:26 a.m., RN-D verified there was no electric shaver in R8's room and at 9:30 a.m., verified R8 had facial hair and stated R8 should be shaved. During interview on 8/30/23 at 9:31 a.m., registered nurse (RN)-B stated R8 was diabetic and there was no specific assignment for shaving, but thought it was the nurse's responsibility and if R8 refused, expected documentation of refusals from all staff. RN-B verified there was no specific task for shaving on the care plan or care sheet, no bath documented since 8/14/23 for R8, no documentation the past three to four months regarding any refusals for shaving, and stated they should have a scheduled task for shaving because the task could get missed if it was not identified on the care plan and care sheet. RN-B added a female resident would not want facial hair.	21805		

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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
21805	Continued From page 32 During interview on 8/30/23 at 9:47 a.m., the director of nursing (DON) stated the aide was responsible for shaving, but if a resident was diabetic, it was the nurse's responsibility. DON stated women should be shaved as needed and expected shaving be completed on bath days adding it was a dignity issue for a female to have facial hair. R6's significant change Minimum Data Set (MDS), dated 7/26/23, indicated R6 was cognitively intact, and required extensive assist of one staff for toileting and personal hygiene. R6's face sheet printed 8/30/23, indicated resident diagnosis included congestive heart failure (CHF), urinary tract infection, and atrial fibrillation. R6's bladder care plan revised on 7/31/23, indicated R6 is occasionally incontinent of bowel and bladder, with goal that included would be free from skin breakdown due to incontinence and from brief use through review date. R6 catheter updated 8/27/23, indicated I have (SIC) catheter or urostomy with interventions that included position catheter bag and tubing below the level of the bladder. Catheter care per facility policy. R6's physician orders dated 8/4/23, included catheter care every shift and as needed. Document output in point of care (POC) record two times a day for catheter maintenance. Catheter bag and/or leg bag covered at all times. During observation and interview on 8/27/23 at 3:11 p.m., R6's catheter was attached to the side	21805		

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	00975	A. BUILDING: _____ B. WING _____	C 08/30/2023

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21805	Continued From page 33 of her wheelchair (w/c) and not in a privacy bag. R6's catheter could be seen from the doorway. During interview, R6 stated, she would prefer the catheter bag be placed in a privacy bag. During observation on 8/29/23 at 1:09 p.m., R6's catheter was attached to the side of her W/C, hooked onto a bag attached to the top side rail attachment on W/C. R6's catheter tubing and catheter bag were at the level of her bladder; catheter bag was not in privacy bag. During interview on 8/30/23 at 10:50 a.m., nursing assistant (NA)-F verified catheter bag was not in privacy bag or below the bladder as should have been to allow urine to drain into the bag. During interview on 8/30/23 at 4:17 p.m., director of nursing (DON) stated, it was the expectation catheter bags were placed in privacy bags and placed below the bladder to prevent urine backing up into the bladder. Facility policy titled Catheter- Care of Indwelling Cath Policy modified on 6/2021, indicated catheter is placed in cloth bag when up in wheelchair and when in bed. Never raise a catheter bag above the level of the bladder. This could increase the chance of a bladder infection. A policy, Resident Care Policy dated February 2016, indicated every resident was to have morning and bedtime cares daily. The procedure included shaving female residents in the am and applying makeup as requested. A policy, Dignity dated September 2015, indicated residents were cared for in a manner and in an	21805		

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21805	Continued From page 34 environment that promoted maintenance and or enhancement of each resident's quality of life. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on dignity and respect. The DON or designee could then interview residents routinely to ensure residents feel their dignity and respect are being maintained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that	21880		10/13/23

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21880	Continued From page 35 provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to initiate a grievance process to address family member (FM) concerns pertaining to level of care changes for 1 of 2 residents (R5) reviewed for grievances. Findings include: R5's quarterly Minimum Data Set (MDS) dated 8/11/23, indicated R5 required extensive assistance for bed mobility, transfers, dressing, eating, toileting, and personal hygiene. R5 did not ambulate in the hall or in room and had a diagnoses of non traumatic brain dysfunction, and Alzheimer's disease and received hospice care.	21880	corrected	

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21880	Continued From page 36 R5's nursing progress note dated 8/22/23, indicated R5 was placed on COVID isolation from 8/1/23 to 8/10/23, due to testing positive for COVID and R5 was back to her baseline. R5's care conference summary progress note dated 8/24/23 at 6:54 a.m., indicated the household coordinator, clinical coordinator, hospice social worker (SW), R5's spouse, and R5's daughter attended the care conference and discussed R5's resource utilization group (RUG) (a system that classifies residents into distinct groups based on the resident's condition and care which determines the daily rate the facility charges for resident's care) change with having COVID. No additional information was provided whether concerns were resolved in the progress note. R5's hospice progress note dated 8/24/23 at 1:26 p.m., indicated the hospice SW attended the care conference and the main concern was finances. The SW note indicated to continue to follow concern. Grievances were reviewed from the past four months and lacked information a grievance report was completed regarding FM-A's concern. During interview on 8/27/23 at 5:21 p.m., FM-A stated R5's level of care was increased for no reason and FM-A was being billed for $641.00 per day adding the only thing they could think of was because R5 was in quarantine for 10 days following COVID. FM-A stated he received a letter R5's level of care was raised and added he would soon be bankrupt. FM-A stated he spoke with registered nurse (RN)-B who thought the reason was due to R5 having COVID, and did not know of any other reason that would prompt an	21880		

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21880	Continued From page 37 increase. FM-A also stated a care conference was completed on 8/24/23 and the social worker (SW) was aware of the situation but did not provide any feedback. During interview on 8/30/23 at 12:10 p.m., registered nurse (RN)-B stated was aware R5's payment went up and added it happened because of COVID isolation. RN-B stated as of 8/24/23, R5 was back to the previous RUG score and added the family must not be aware of it because it was six days ago. R5's family had concerns despite having a care conference and added the review was ongoing. RN-B was not responsible for explaining the information to FM-A. RN-B stated when families bring up concerns, he tries to talk to the family right away and looks for the correct people to respond to them and added he completed grievance forms in the past, but did not complete a form regarding R5 and added the SW usually addressed concerns. During interview on 8/30/23 at 12:23 p.m., SW-A stated a care conference was completed the week prior. SW-A further stated R5's daily rate went up significantly from $396.00 to $641.00 and added when families express concerns regarding RUGS, they direct the families to complete an appeal. SW-A further stated when a resident's family or resident inform staff of a concern, she completes a grievance form, identifies what the grievance is and follows up timely with the appropriate party. Once there are additional details, SW-A stated she follows up with the family and the form is turned in to the administrator. SW-A further stated they maintain a log of grievances, the date, and how the grievance was addressed, and the families reaction and identified the purpose of the	21880		

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21880	Continued From page 38 grievance process was to allow family the opportunity to express concerns and the facility can follow up to assure the concern does not go un-addressed. During interview on 8/30/23 at 12:33 p.m., the administrator stated concerns were addressed right away for example nurse would start a grievance form and the household coordinator follows up timely to assure the pieces are addressed. The administrator stated she has not been notified of any grievances related to finances and further stated the household coordinator would connect the family with the biller. A policy, Quality Concern/Grievance Process dated January 2023, indicated quality concern forms were available to any resident, resident representative, visitor, staff, or vendor. the policy further indicated if a concern/grievance was filed orally the staff member receiving the information should write a brief description of the concern. The concern/grievance would be addressed minimally within five working days and action items would be communicated to the individual filing the grievance unless indicated as anonymous. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents complaints and grievances are being addressed promptly. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) complaints and grievances are addressed on a timely basis. The results of these audits will be reviewed by the quality assessment	21880		

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21880	Continued From page 39 committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		