CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZGRT

Facility ID: 00975

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

MEDICARE/MEDICAID PROVIDER N (L1) 245424 2.STATE VENDOR OR MEDICAID NO. (L2) 369842400 5. EFFECTIVE DATE CHANGE OF OWN		3. NAME AND ADD (L3) PRESBYTERI (L4) 3220 LAKE JC (L5) ARDEN HILL	IAN HOMES OF OHANNA BOUL S, MN	F ARDE LEVARI		4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
(L9)	EKSHIF	7. PROVIDER/SUPF 01 Hospital		9 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 11/21/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	012 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	07 X-Ray 1	10 NF 11 IMR 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY IS	CERTIFIED AS:			
From (a):		X A. In Compliance	e With		And/Or Approved Waivers Of Th	e Following Requirements:
To (b):		Program Re Compliance			2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	208 (L18)	1. Ac	cceptable POC		4. 7-Day RN (Rural SNF 5. Life Safety Code	_
13.Total Certified Beds	208 (L17)		pliance with Program ts and/or Applied Wa		* Code: A *	(L12)
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IMR		1861 (e) (1) or 1861 (j) (1):	(L15)
208						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABL	E SHOW LTC CANCEL	LATION DATE):			
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Susanne Reuss, Unit Super	wicor	1.1	1/26/2012		Shellae Dietrich, Prog	mam Cmanialist
Susaime Reuss, Omit Super	VISOI		1/26/2012	(L19)	Shenae Diethen, Frog	ram Specialist 12/05/2012 (L20)
					L OFFICE OR SINGLE STA	12, 03, 201 (L20)
	RT II - TO BE	E COMPLETED B 20. COMP		IONA	L OFFICE OR SINGLE STA	ATE AGENCY cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
PA 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Particular Security of the Particular Security 1. Facility is not Eligible	RT II - TO BE	E COMPLETED B 20. COMP RIGH	SY HCFA REG	VIL	21. 1. Statement of Finan 2. Ownership/Control	ATE AGENCY cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
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CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN# 24-5424

At the time of the standard survey completed October 4, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On November 21, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on October 4, 2012, effective November 13, 2012. Therefore, the remedies outlined in our letter dated October 18, 2012, will not be imposed. See attached CMS-2567B forms for the results of the November 21, 2012 revisit.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5424 December 5, 2012

Ms. Lisa Kalla, Administrator Presbyterian Homes of Arden Hills 3220 Lake Johanna Boulevard Arden Hills, Minnesota 55112

Dear Ms. Kalla:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 13, 2012 the above facility is certified for:

208 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health P.O. Box 64900

St. Paul, MN 55164-0900

Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

November 26, 2012

Ms. Lisa Kalla, Administrator Presbyterian Homes of Arden Hills 3220 Lake Johanna Boulevard Arden Hills, Minnesota 55112

RE: Project Number S5424022

Dear Ms. Kalla:

On October 18, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 4, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 21, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 4, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 13, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 4, 2012, effective November 13, 2012 and therefore remedies outlined in our letter to you dated October 18, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5424r112.rtf

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building		(Y3) Date of Revisit 11/21/2012
	245424	B. Wing		
Name	of Facility		Street Address, City, State, Zip Code	
PR	ESBYTERIAN HOMES OF ARDEN HILL	S	3220 LAKE JOHANNA BOULEVAR	D
			ARDEN HILLS MN 55112	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4	Item	((Y5)	Date
ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii		Correction Completed 11/13/2012 4)		ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 11/13/2012		ID Prefix Reg. # LSC	F0274 483.20(b)(2)(ii)		Correction Completed 11/13/2012
ID Prefix	F0279 483.20(d), 483.20		Correction Completed 11/13/2012		ID Prefix	F0309 483.25		Correction Completed 11/13/2012		ID Prefix Reg. #	F0314 483.25(c)		Correction Completed 11/13/2012
ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 11/13/2012		ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 11/13/2012		ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 11/13/2012
ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC								
ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC								
Reviewed By		eviewed B	зу	Da	te: 11/26/12	Signature o	of Surve	=				Date: 11/21	1/12
Reviewed By	,	eviewed B	Зу	Da		Signature o						Date:	
Followup to	Survey Complete 10/4/20						-				a Summary of to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZGRT

Facility ID: 00975

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

MEDICARE/MEDICAID PROVIDER N (L1) 245424 2.STATE VENDOR OR MEDICAID NO. (L2) 369842400	0.	3. NAME AND ADDR (L3) PRESBYTERIA (L4) 3220 LAKE JOI (L5) ARDEN HILLS		4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUPPL	IER CATEGORY 05 HHA 09 E	02 (L7) RD 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 10/04/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	03 SNF/NF/Distinct	06 PRTF 10 N 07 X-Ray 11 IN 08 OPT/SP 12 R	IR 15 ASC	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 208 (L37) (L38)	208 (L18) 208 (L17) 19 SNF (L39)	X B. Not in Compli	With uirements	And/Or Approved Waivers Of T 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN)5. Life Safety Code s: *Code: *B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit7. Medical Director
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABL	E SHOW LTC CANCELL	ATION DATE):		
See Attached Remarks 17. SURVEYOR SIGNATURE		Date :		18. STATE SURVEY AGENCY	APPROVAL Date:
Vidya Tomar, HFE NE II			30/2012 _{(L}	Shellae Dietrich, Pro	
PAI	RT II - TO BE	COMPLETED BY	HCFA REGIO	NAL OFFICE OR SINGLE ST	
DETERMINATION OF ELIGIBILITY	cipate		IANCE WITH CIVIL TS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
	(L21)				
22. ORIGINAL DATE OF PARTICIPATION	(L21) 23. LTC AGREEM BEGINNING		LTC AGREEMENT ENDING DATE	26. TERMINATION ACTION: VOLUNTARY 0	(L30) <u>0</u> <u>INVOLUNTARY</u>
	23. LTC AGREEM	DATE		VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem	0 INVOLUNTARY 05-Fail to Meet Health/Safety nent 06-Fail to Meet Agreement
OF PARTICIPATION 02/01/1987 (L24)	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI	DATE VE SANCTIONS of Admissions:	ENDING DATE (L25) (L44)	VOLUNTARY 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety nent 06-Fail to Meet Agreement
OF PARTICIPATION 02/01/1987 (L24) 25. LTC EXTENSION DATE: 2	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind Sus	DATE VE SANCTIONS of Admissions: pension Date:	(L25) (L44) (L45)	VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	0 INVOLUNTARY 05-Fail to Meet Health/Safety nent 06-Fail to Meet Agreement OTHER 07-Provider Status Change
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CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN# 24-5424

At the time of the standard survey completed October 4, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 6542

October 18, 2012

Ms. Lisa Kalla, Administrator Presbyterian Homes of Arden Hills 3220 Lake Johanna Boulevard Arden Hills, Minnesota 55112

RE: Project Number S5424022

Dear Ms. Kalla:

On October 4, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 13, 2012, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 4, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 4, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5424s13.rtf

PRINTED: 10/18/2012 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245424	B. WIN	√G		10/0	4/2012
	ROVIDER OR SUPPLIER	ARDEN HILLS		32	EET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		1233 1871 - 1871 1871 - 1871
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F 000	INITIAL COMMEN	rs	F	000	Recieved 10/29	1/12	
F 225 SS=D	WILL SERVE AS Y COMPLIANCE UPO ACCEPTANCE. YO BOTTOM OF THE CMS-2567 FORM V VERIFICATION OF UPON RECEIPT O AN ONSITE REVISE CONDUCTED SUBSTANTIAL COREGULATIONS HACCORDANCE WI 483.13(c)(1)(ii)-(iii), INVESTIGATE/REFALLEGATIONS/INITED The facility must no been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must en involving mistreatm including injuries of misappropriation of immediately to the acceptance.	F AN ACCEPTABLE POC, IT OF YOUR FACILITY MAY TO VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION. (c)(2) - (4) PORT DIVIDUALS It employ individuals who have fabusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wiedge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies. Sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and	10/30/1 SEY	2 2 2 2 2 2 2	It is the policy of Johanna Shorall allegations of mistreatment, or abuse are immediately report the administrator and thorough investigated. To ensure continuous tompliance the following plant been implemented: The Vulnerable Adult Policy was reviewed and remains accurate lift transfer policy was reviewed remains accurate. Fact finding investigation of re 131's allegations was investigation notification by surveyor, been seen monthly by house, psychologist who indicated on 10/05/12 VA "continues to be paranoid". The resident has a diagnosis of Dementia and a documented history of making statements that cannot be substantiated Investigation of 131's and resident 53's allegal abuse were reviewed and investingings and interventions were OHFC with no further action	neglect orted to only oned has as e. Likko d and sident ated VA has resident tions of estigative	1/13/12
	through established	procedures (including to the			necessary.		(X6) DATE

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	COMPLE	
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F 225	State survey and control of the facility must have violations are thorough prevent further potential in the results of all into the administrator representative and with State law (includent, and if the	ertification agency). Eve evidence that all alleged ughly investigated, and must ential abuse while the rogress. Every extigations must be reported	F:	2225	Policy was provided to all state the week of10/15/12 and 10/2 include documentation of time notification of the administrate immediate reporting to state. Random audits will be completed weekly for 4 weeks and month months to ensure documentatimely notification of administimediate or asap reports to agency. Audits will be review meeting for direction or channecessary and determine if	aff during 22/12 to ely or and agency. eted thiy for 2 ation of trator and state yed at QA ge if	20 A A A A A A A A A A A A A A A A A A A
	by: Based on interview facility failed to ens immediately reported the residents (R131) abuse; in addition, allegations of mistred State Agency (SA) R131) reviewed for Findings include: The facility failed to allegations of rough administrator and S	6A.			continuation of audits is need on compliance results. The Administrator and/or de are responsible for ongoing compliance. Date certain for ongoing cor 11/13/2012	- signee	3.70x
	assistants had take during the day shift	7 a.m. R131 stated nursing in her call light away at times and approximately one month ants placed her in the sling of					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		G	COMPL	
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F 225	a mechanical lift and bed for roughly a has staff had placed so in a formation which body. R131 stated adjust the soaker por R131 stated she rephousehold coordinaresolved the concerwas afraid to ask stano longer felt staff beher. R131's diagnoses in degeneration, left end and stated 8/22/12, indictinated. R131's Minim 8/22/12, noted no stated 8/22/12, indictinated. R131's Minim 8/22/12, noted no stated s	d left her "hanging over" her alf an hour. R131 also stated aker pads on her bed at night in created a lump under her when she asked staff to ads, staff laughed at her. borted these incidents to the ator (HC)-B, but HC-B had not ans. R131 then explained she aff for anything because she believed her or cared about included depression, macular are blindness and stroke. The lental Status (BIMS, a tool uating cognitive function) ated R131 was cognitively num Data Set (MDS) dated amptoms of psychosis such delusions were present. The ober 2012 target behavior are shifts indicated R131 ce of "delusions - false fixed aciplinary staff Progress Notes 4/12, indicated no evidence of ion was displayed by R131. I 12/31/11, indicated R131 and directed staff to use the	F2	225			2012 0.450 0.381

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIPL ILDING	E CONSTRUCTION	(X3) DATE S COMPL	
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F 225	her fingernails to "c R131 also recount about two weeks a privacy curtain whi the room. R131 re was "humiliated." F but darn I don't des told the HC-B abou approximately thre was not resolved. I different male staff about the other con	was uncomfortable, and used dig" into R131 during a bath. ed an incident which occurred go, when staff did not close the le her roommate had guests in ported she was not clothed and R131 added, "I know I am old, serve that." R131 stated she at the call light concerns e weeks ago, but the issue R131 stated she told two members (identity unknown)	F	225			20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
	not informed her o members. HC-B st {R131} so she feel HC-B was informe	f any concerns about staff ated, she "can speak with s like it is followed up on." After d of all of R131's above listed stated R131 had a history of					1 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 /
	stated HC-B had re staff were "mean to 9:00 a.m. and 9:30 R131's description allegations had bee was trying to get a alleged perpetrator administrator state concerns about mis but since the facility	27 a.m. the administrator eported R131 made allegations of her," this morning between a.m. The administrator stated of the alleged perpetrator and en "confusing" and the facility better description of the and allegations. The d staff usually brought streatment to her immediately, y believed R131 was were going to investigate.					7. V. O. V.
	on the morning of	3 stated she interviewed R131 10/4/12 because R131 was ied to interview her last night.			•		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		245424	B. WIR	۱G		10/0	4/2012
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F 225	HC-B stated R131 lift" for over thirty m identifying staff menthe director of nursi approximately 3:00 At 10:45 a.m. the ashe did not know all approximately 9:30 (approximately 19 hinformed HC-B of Fadministrator stated and left in bed over everything else". The facility had not report 11:15 a.m. the admirant substantiate and left substantiate.	described being in a "cage like inutes and had difficulty mbers. HC-B stated she told ing about R131's concerns at p.m. on 10/3/12. administrator again confirmed bout R131's concerns until a.m. on 10/4/12 nours after the surveyor R131's allegations). The d' it was about being in a cage an hour, can't remember ne administrator confirmed the orted the incident to the SA. At inistrator stated the facility abuse" regarding R131's	F:	225			5.30 0.00 0.391
•	delusional and R13 dementia." On 10/4 administrator stated R131's allegations reported to the SA, the allegations were administrator stated	e the facility believed they were 1 was diagnosed with "senile 1/12, at 12:00 p.m. the 1/12, at 12:00 p.m. the 1/12 did not agree needed to be immediately because the facility believed to based on delusions. The 1/12 dishe believed a report needed to 3A within 24-hours of an 1/12 did not senior to the senior					to hon
	verbal abuse imme R53's diagnoses infailure, hypertension falls. The care ar 5/30/12, indicated F	report R53's allegations of diately to the SA. cluded congestive heart in and a personal history of rea assessment (CAA) dated R53 was cognitively aware of and able to use the call light					14. (1. (1. (1. (1. (1. (1. (1. (1. (1. (1

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			COMPL	
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
An incident report of on 9/09/12, indicate assistant threatener R53 would be unab report indicated a staren't going to wast else's" (in regards to transferring from the An electronic messis administrator by the dated 9/8/12, at 6:2 spouse had informer regarding a nursing such as "we are not went to bed" and putting you to bed at On 10/4/12, at appropriated he was made maltreatment (verba 6:30 p.m. on 9/8/12 report the allegation morning on 9/9/12. A review of the Vulr Prevention Plan dat directed staff, "I. Int Investigation Proces maltreatment must employee's supervisireport it immediately contact the Clinical Reporting and Investigation Processing and Investigation as Investigation and Investigation	lated as submitted to the SA and R53 alleged a nursing do to disable the call light so alle to request assistance. The taff member told R53 "you see my time anymore or anyone to requesting assistance for the bed to the wheelchair). age (email) sent to the ecclinical manager (CM)-B and the facility of a concern assistant making statements to going to get you up You just "I am not going waste time and then getting you up" Toximately 11:00 a.m. CM-B aware of R53's allegations of all abuse) at approximately . CM-B confirmed he did not a to the SA until the next the same and then getting and dures All cases of be reported immediately to an sor (or designee) who will then by to the Administrator who will Administrator if needed."; "VI estigating, Reporting Resident	F	225			20 (2) (2) (2) (3) (3) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4
			to and the second second second			
	ROVIDER OR SUPPLIER TERIAN HOMES OF A SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From particular consistently to call the consistent consistently to call the	TERIAN HOMES OF ARDEN HILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 consistently to call for assistance. An incident report dated as submitted to the SA on 9/09/12, indicated R53 alleged a nursing assistant threatened to disable the call light so R53 would be unable to request assistance. The report indicated a staff member told R53 "you aren't going to waste my time anymore or anyone else's" (in regards to requesting assistance for transferring from the bed to the wheelchair). An electronic message (email) sent to the administrator by the clinical manager (CM)-B dated 9/8/12, at 6:23 p.m. indicated R53 and her spouse had informed the facility of a concern regarding a nursing assistant making statements such as "we are not going to get you upYou just went to bed" and "I am not going waste time putting you to bed and then getting you up" On 10/4/12, at approximately 11:00 a.m. CM-B stated he was made aware of R53's allegations of maltreatment (verbal abuse) at approximately 6:30 p.m. on 9/8/12. CM-B confirmed he did not report the allegation to the SA until the next	TROVIDER OR SUPPLIER TERIAN HOMES OF ARDEN HILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 consistently to call for assistance. 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A review of the Vulnerable Adult Abuse Prevention Plan dated as updated April 2012, directed staff, "I. Internal Reporting and Investigation Procedures All cases of maltreatment must be reported immediately to an employee's supervisor (or designee) who will then report it immediately to the Administrator who will contact the Clinical Administrator if needed."; "VI Reporting and Investigating, Reporting Resident Maltreatment, Pursuant to state and federal	ROVIDER OR SUPPLIER TERIAN HOMES OF ARDEN HILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 consistently to call for assistance. An incident report dated as submitted to the SA on 9/09/12, indicated R53 alleged a nursing assistant threatened to disable the call light so R53 would be unable to request assistance. 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An electronic message (email) sent to the administrator by the clinical manager (CM)-B dated 9/8/12, at 6:23 p.m. indicated R53 allegations of maltreatment (verbal abuse) at approximately 4:00 a.m. CM-B stated he was made aware of R53's allegations of maltreatment (verbal abuse) at approximately 6:30 p.m. on 9/8/12. CM-B confirmed he did not report the legation to the SA until the next morning on 9/9/12. A review of the Vulnerable Adult Abuse Prevention Plan dated as updated April 2012, directed staff." Internal Reporting and Investigation Procedures All cases of maltreatment must be reported immediately to an employee's supervisor (or designee) who will then report it immediately to the Administrator who will contact the Clinical Administrator if needed." 'VI Reporting and Investigation, Pursuant to state and federal

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
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	PROVIDER OR SUPPLIER	ARDEN HILLS		32	REET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		vi.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226 SS=D	and Services to requaltreatment of addrendered vulnerable mental disability, ar provision of care and unwilling to report succord."; "Internal ling Agency: Immediate Agency." On 10/4/12, at 12:00 stated she believed to the SA within 24-made. 483.13(c) DEVELO. ABUSE/NEGLECT, The facility must depolicies and proced mistreatment, negle and misappropriation. This REQUIREMENT by: Based on interview facility failed to implepolicy regarding immore frough treatment to residents (R131); in implement the policy allegations of mistrestreatments.	uire reporting of the ult residents, who are be by reason of physical or e relying on the institution for ad are deemed to be unable or uch treatment of their own nvestigative Steps: I. State ly make a report to the State 0 p.m. the administrator a report needed to be made hours of an allegation being P/IMPLMENT ETC POLICIES velop and implement written		225	It is the policy of Johanna Shore all allegations of mistreatment, or abuse are immediately report the administrator and thoroughly investigated. To ensure continu compliance the following plan habeen implemented: The Vulnerable Adult Policy was reviewed and remains accurate lift transfer policy was reviewed remains accurate.	neglect ted to y ued as	2012 0VF0 10 2351

PRINTED: 10/18/2012 FORM APPROVED OMB NO. 0938-0391

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F 226	The Vulnerable Adulated as updated A Reporting and Inversases of maltreatm immediately to an edesignee) who will the Administrator if nee	ge 7 Ilt Abuse Prevention Plan pril 2012 directed, "I. Internal stigation Procedures, All ent must be reported mployee's supervisor (or then report it immediately to ho will contact the Clinical ded."; "VI Reporting and rting Resident Maltreatment,	F2	226	Fact finding investigation of res 131's allegations was investiga upon notification by surveyor. been seen monthly by house psychologist who indicated on 10/05/12 VA "continues to be paranoid". The resident has a diagnosis of Dementia and a	ted	012 012 0 105
·	Pursuant to state as policy of Presbyteria require reporting of residents, who are soft physical or menta institution for provis be unable or unwillistheir own accord."; " I. State Agency: I the State Agency."	and federal regulations, it is the an Homes and Services to the maltreatment of adult rendered vulnerable by reason al disability, are relying on the ion of care and are deemed to ng to report such treatment of 'Internal Investigative Steps: mmediately make a report to implement their abuse			documented history of making statements that cannot be substantiated Investigation of making 131's and resident 53's allegation abuse were reviewed and investing the statement of the version of the Vulnerable Policy was provided to all staff.	ons of stigative sent to Adult during	9301 976 976 976 976 976 976 976 976
	allegations of rough	eatment) to the administrator		THE PERSON NAMED OF THE PERSON NAMED IN	the week of10/15/12 and 10/22 include documentation of timely notification of the administrator immediate reporting to state ag	y and	
	assistants had take during the day shift ago, nursing assista a mechanical lift and bed for roughly a hastaff had placed soa in a formation which body. R131 stated adjust the soaker particularly.	7 a.m. R131 stated nursing in her call light away at times and approximately one month ants placed her in the sling of d left her "hanging over" her alf an hour. R131 also stated aker pads on her bed at night a created a lump under her when she asked staff to ads, staff laughed at her. borted these incidents to the tor (HC)-B, but HC-B had not			Random audits will be complete weekly for 4 weeks and monthly months to ensure documentation timely notification of administration immediate or asap reports to significant agency. Audits will be reviewed meeting for direction or change necessary and determine if continuation of audits is needed on compliance results.	y for 2 on of tor and tate d at QA	

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	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SI COMPLE						
		245424	B. WII	VG		10/0	04/2012
	PROVIDER OR SUPPLIER	ARDEN HILLS		32	EET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		*** ***
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	was afraid to ask st no longer felt staff it her. During a follow up in p.m. R131 again regard a mechanical lift aft when the incident of September. R131 sassistant (identity usus call light away, place her in a way which wher fingernails to "d R131 also recounte about two weeks agprivacy curtain while the room. R131 repwas "humiliated." R but darn I don't destold the HC-B about approximately three was not resolved. R	rns. R131 then explained she aff for anything because she believed her or cared about interview on 10/3/12, at 1:41 ported staff "strung [her] up" in er a bath. R131 was unsure of ccurred, but believed it was in tated an older nursing inknown) frequently took her sed soaker pads underneath was uncomfortable, and used ig" into R131 during a bath. It dan incident which occurred go, when staff did not close the enter roommate had guests in orted she was not clothed and 131 added, "I know I am old, erve that." R131 stated she is the call light concerns the weeks ago, but the issue it at the clothed she told two members (identity unknown)	F:	226	The Administrator and/or desig are responsible for ongoing compliance. Date certain for ongoing compl 11/13/2012		7.00 (2.2) 7.00 (2.2)
	not informed her of members, HC-B sta {R131} so she feels HC-B was informed	p.m. HC-B stated R131 had any concerns about staff ated, she "can speak with like it is followed up on." After of all of R131's above listed tated R131 had a history of aren't there."		e de la companya de l			
	stated HC-B had re staff were "mean to	7 a.m. the administrator ported R131 made allegations her," this morning between a.m The administrator stated		AND I SHEW STREET, STR			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	AULTIPL ILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		245424	B. Wil	NG		10/	04/2012
	PROVIDER OR SUPPLIER	ARDEN HILLS		322	ET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	R131's description allegations had bee was trying to get a la alleged perpetrator administrator stated concerns about mis but since the facility "delusional," they was to the morning of 1 resting when she tri HC-B stated R131 of lift" for over thirty midentifying staff mer the director of nursi approximately 3:00. At 10:45 a.m. the ads she did not know at approximately 9:30 (approximately 19 hinformed HC-B of Radministrator stated and left in bed over everything else" The facility had not repo 11:15 a.m. the administrator stated allegations because delusional and R13 dementia." On 10/4 administrator stated R131's allegations were administrator stated administrator stated administrator stated R131's allegations were administrator stated	of the alleged perpetrator and en "confusing" and the facility better description of the and allegations. The district streatment to her immediately, believed R131 was were going to investigate. It is stated she interviewed R131 o/4/12 because R131 was ied to interview her last night. described being in a "cage like inutes and had difficulty mbers. HC-B stated she tolding about R131's concerns at p.m. on 10/3/12. It is a concerns at continued bout R131's concerns until	F	226			20 12 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLI	
		245424	B. WII	1G _		10/0	4/2012
	PROVIDER OR SUPPLIER SYTERIAN HOMES OF A	ARDEN HILLS		32	REET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	allegation being ma The facility failed to prevention policy ar	implement their abuse nd report R53's allegations of	F 2	226			
	on 9/09/12, indicate assistant threatener system so R53 wou assistance. The retold R53 "you aren't anymore or anyone	lated as submitted to the SA ed R53 alleged a nursing d to disable the call light all be unable to request port indicated a staff member t going to waste my time else's" (in regards to use for transferring from the					2012 - VEUD - 2011
	administrator by the dated 9/8/12, at 6:2 spouse had informe regarding a nursing such as "we are not went to bed" and	age (email) sent to the eclinical manager (CM)-B 3 p.m. indicated R53 and hered the facility of a concern assistant making statements t going to get you upYou just "I am not going waste time and then getting you up"					182X
	stated he was made maltreatment (verba 6:30 p.m. on 9/8/12	oximately 11:00 a.m. CM-B e aware of R53's allegations of al abuse) at approximately . CM-B confirmed he did not not to the SA until the next				,	
	stated she believed	0 p.m. the administrator a report needed to be made hours of an allegation being			•		entari.
F 274 SS=D		MPREHENSIVE ASSESS NT CHANGE	F2	74			males.

	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING						
		245424	B. WIN	۱G		10/0	04/2012
	PROVIDER OR SUPPLIER	ARDEN HILLS		32	EET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 274	A facility must con assessment of a rescility determines that there has bee resident's physical purpose of this seemeans a major de resident's status the itself without further implementing standinterventions, that one area of the resident's interventions, that one area of the resident's interventions, that one area of the resident's interventions, that one area of the resident interventions, that one area of the resident interventions, that one area of the resident interventions, are plan, or both. This REQUIREMED by: Based on record if failed to complete assessment for 1 complete	duct a comprehensive esident within 14 days after the cor should have determined, in a significant change in the or mental condition. (For ection, a significant change cline or improvement in the nat will not normally resolve er intervention by staff or by dard disease-related clinical has an impact on more than esident's health status, and elinary review or revision of the has significant change of 3 residents (R109) in the opment of blisters on the heart failure, a blister on top of reakness and swelling, Deep DVT), Diabetes Mellitus and care focused plan of care.	F2	274	It is the policy of Johanna Sho each resident has a compreheassessment with in 14 days or significant change of condition develop a plan that meets the each resident and ensures the physical, mental and psychos being. To ensure continued compliance the following plan been implemented: The policy for completion of Morelated assessment known as Risk Policy was reviewed and appropriate. Resident 109 is no longer in offacility. Residents are assessed for comprehensive skin condition admission, with a new unset of condition and with any significant change in condition in conjunct the RAI process. All residents current skin conditions have be reviewed and reassessed as Re-education for household seregards to Comprehensive Sk Assessment policy to include documentation of all skin conditions again 10/29/12 and again 10/29/12	ensive of n to e needs of eir social well has MDS s the Skin d remains our as upon of a skin cant ction with s with been needed. staff in kin accurate ditions k of	1/13/12

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		245424	B. WIN	IG		10/0	4/2012
	ROVIDER OR SUPPLIER	ARDEN HILLS		32	EET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 274	A significant chang assessment dated having cognitive ar required extensive activities of daily livand used a wheeld indicated R109 was pressure ulcers an ulcers, nor any ven associated Care At 08/27/12, indicated declined and was rathe CAA indicated alteration due to imnon-weight bearing assistance with all every two hours. R109's Braden Scapressure sore risk) R109 as being at a The correlating Ski indicated R109 had right foot and was a The Wound Asses 06/01/12, through 0 on top of right foot The Weekly Bath S7/20/12, identified R109 had intact" on the front thighs.	le Minimum Data Set (MDS) 8/27/12, identified R109 as and memory impairments; assistance from staff with all ving (ADL) including transfers hair for mobility. The MDS as at risk for developing d did not have any pressure rous or arterial ulcers. The rea Assessment (CAA) dated I R109's health status had receiving hospice services. R109 was at risk for skin repaired physical mobility, a status, needing staff ADLs and was repositioned ale (a tool used for predicting dated 06/01/12, identified a mild risk for skin break-down. In Risk Data Collection form d a opened blister on top of the at mild risk for skin breakdown. sment Flow Sheet dated 06/27/12, indicated the blister	F 2	274	Random audits will be complete weekly for 4 weeks and monthly months to ensure accurate documentation of skin condition. Audits will be reviewed at QA m for direction or change if necess and determine if continuation of is needed based on compliance results. The Clinical coordinator and/or designee are responsible for or compliance. Date certain for ongoing compliance.	y for 2 ns. neeting sary f audits	2012 . VCD -
		R109 had a 3.0 cm by 1.5 cm					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		245424	B. WIN	G_		10/0	4/2012
	ROVIDER OR SUPPLIER	ARDEN HILLS		3	REET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD IRDEN HILLS, MN 55112		. 4x
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 274	open blister on the on the bilateral thigh thigh)-NP (nurse processed for this bilateral thigh)-NP (nurse processed for this bilateral thigh this bilateral thigh the collection form (a trepositioning needs "Skin intact, rednes Continue to repositioning the document the multiple thighs. Although state open/closed blisters Collection form, the evidence of any skin an individualized cathese blisters, prevention of the complications due to condition. On 10/04/12, at 12: (DON) reviewed R1	right inner knee and blisters hs, "(One in the front of each	F 2	274			2012 VED 3391
F 279 SS=D	lacking. 483.20(d), 483.20(k COMPREHENSIVE A facility must use to develop, review a comprehensive plan The facility must deplan for each reside	he results of the assessment and revise the resident's of care.	F 2	79	F279 It is the policy of Johanna Shor each resident has a Comprehe Care Plan developed based on individual assessment results. ensure continued compliance the following plan has been implement.	nsive To he	11/13/12
	objectives and times	tables to meet a resident's					1.15

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		245424	B. WIN	NG		10/0	4/2012
	ROVIDER OR SUPPLIER TERIAN HOMES OF	ARDEN HILLS		3	REET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		392
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPERTY)	ULD BE	(X5) COMPLETION DATE
F 279	medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident's §483.10, including tunder §483.10(b)(4	nd mental and psychosocial tified in the comprehensive describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment.	F2	2279	The care planning policy has reviewed and remains accura care plans are reviewed and uninconjunction with the RAI proinclude changes in condition. A comprehensive re-assessment resident 53 was completed to repositioning needs. Based of assessment results a reposition was developed and document resident #53's care plan. Re-education on developing a comprehensive care plan and	te. All updated occess to nent of identify on plan ted on	012 97 p 1391
	by: Based on interview facility failed to deverge repositioning and residents (R53) residents (R53) residents (R53) residents (R53) residents (R53) lacked a care prequency of reposition refusals to be reposited refusals to be reposited resident in joint, disease, and periphannual Minimum Daindicated R53 was extensive assistant totally dependent for Score (a tool used to development) dated	and document review, the elop a care plan to address efusals of repositioning for 1 of eviewed with pressure ulcers. Colan which identified the tioning and addressed R53's sitioned. to include congestive heart diabetes, chronic kidney leral vascular disease. The lata Set (MDS) dated 5/24/12, cognitively intact, required the with bed mobility and was or transfers. The Braden to predict pressure ulcer 15/18/12, was 15 indicating re ulcer development. The			planning policy was provided Household staff during the we 10/15/12 and again 10/29/12 Random audits will be comple weekly for 4 weeks and month months to ensure accurate development and completion plans based on assessment Audits will be reviewed at QA for direction or change if necessand determine if continuation is needed based on compliar results.	for all elek of eled only for 2 of care data. A meeting essary of audits	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	COMPLE	
		245424	B. WII	۷G		10/0	4/2012
	ROVIDER OR SUPPLIER	ARDEN HILLS		3	REET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		2.73 2.73 7.33 7.33
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	undated Comprehe form indicated the revery two hours wheelchair. R53's care plan datidentified a problem diabetic ulcer on a ulcers on the coccy in bed and with transfer interventions indicated for all transfers, need mobility, and id be positioned on hedirection on how of repositioned while in the reventioned while in the reverse of the repositioned while in the reverse of the	ge 15 nsive Skin Data Collection resident was to be repositioned ile in bed and/or in the red as initiated on 5/25/12, n with skin integrity related to toe, two stage two pressure x, and a problem with mobility refers. The care plan ted R53 was totally dependent reded extensive assistance with rentified the resident refused to rer sides. The care plan lacked ten R53 should have been n bed or in the wheelchair and s to address R53's refusals to	F	279	The Clinical Administrator an designee are responsible for compliance. Date certain for ongoing com 11/13/2012.	ongoing	2012 (2012 (2012 (2012 (2013 (
	(CM)-C stated R53 non-compliant with the current care plate reposition R53 and address R53's refuse CM-C stated the caupdated. 483.25 PROVIDE CHIGHEST WELL BEACH resident must provide the necession maintain the high mental, and psychological.	5 a.m. the clinical manager could sometimes be repositioning. CM-C verified in lacked direction to lacked interventions to sals to be repositioned. In plan should have been CARE/SERVICES FOR EING It receive and the facility must ary care and services to attain lest practicable physical, in ecomprehensive assessment	F	309			200 300 and 100 and 10

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVICE COMPLETED				
		245424	B. WII	NG _		10/0	4/2012
	PROVIDER OR SUPPLIER	ARDEN HILLS	·	3:	REET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	This REQUIREMENT by: Based on interview facility failed to ensucquired skin wound determine and proving treatment to promo 3 residents (R109) alteration. Findings include: R109 developed fluthighs during her stinterventions developed skin. R109 was admitted include congestive the right foot, leg with vein Thrombosis (I was on a palliative of R109 died on 09/12 A significant changuassessment dated having cognitive an required extensive activities of daily livand used a wheelcl	and document review, the ure residents with facility ds were assessed to ide the necessary care and the healing and comfort for 1 of in the sample with a skin id filled blisters on the bilateral ay and did not have upped to address these blisters hensive re-assessment of the on 6/1/12, with diagnoses to heart failure, a blister on top of eakness and swelling, Deep DVT), Diabetes Mellitus and care focused plan of care. 1/12 at the facility. In Minimum Data Set (MDS) 8/27/12, identified R109 as d memory impairments; assistance from staff with all ing (ADL) including transfers nair for mobility. The MDS	F	309		d to all at level of ed has een e. All pdated acess. s upon change with the aff in n accurate itions	2012 2012 2012 2013 2013 2013 2013 2013
	pressure ulcers and ulcers, nor any ven- associated Care Ar	at risk for developing I did not have any pressure ous or arterial ulcers. The ea Assessment (CAA) dated R109's health status had			documentation of skin condition Audits will be reviewed at QA in for direction or change if neces and determine if continuation o	neeting sary	

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE S COMPL	
		245424	B. WIN	IG		10/0	04/2012
	ROVIDER OR SUPPLIER	ARDEN HILLS		32	EET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	declined and was n The CAA indicated alteration due to im non-weight bearing	age 17 eceiving hospice services. R109 was at risk for skin epaired physical mobility, status, needing staff ADLs and was repositioned	F3	309	results. The Clinical coordinator and/or designee are responsible for or compliance.	ngoing	
	pressure sore risk) R109 as being at m The correlating Ski indicated R109 had right foot and was a The Wound Assess	ale (a tool used for predicting dated 06/01/12, identified hild risk for skin break-down. In Risk Data Collection form a opened blister on top of the lat mild risk for skin breakdown. In Sment Flow Sheet dated 16/27/12, indicated the blister was healed.			Date certain for ongoing complete 11/13/2012.	iance is	1012 160 191 101 101 101 101 101 101 101 101 10
	7/20/12, identified F centimeter (cm) x 0 thigh; on 8/24/12, a identified R109 had	Skin Assessment form dated R109 had developed a 0.9 0.5 cm blister on the left front and 8/30/12, the forms I "ruptured blisters, some and back of her bilateral				•	1 (A)
	8/09/12, indicated for open blister on the	care plans dated 8/05/12, and R109 had a 3.0 cm by 1.5 cm right inner knee and blisters hs, "(One in the front of each ractitioner) update."					
	COLLECTION" significantified R109 had blisters on the bilater right front thigh." Revaluation form (a total content of the con	PREHENSIVE DATA nificant change dated 8/23/12, I small open and fluid filled eral upper thighs, "(back) & 109's Tissue Tolerance tool used to determine s) dated 08/23/12, indicated,					

Event ID: ZGRT11

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLI	
		245424	B. WIN	IG		10/0	04/2012
	PROVIDER OR SUPPLIER	ARDEN HILLS		32	EET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID. PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	"Skin intact, rednes Continue to repositi staff performing the document the multi thighs. Although sta open/closed blisters Collection form, the evidence of any ski an individualized ca these blisters, preve complications due to condition.	ge 18 s present and bleachable. on as CP (care plan)." The skin evaluation failed to ple blisters on R109's upper off had documented multiple on the Comprehensive Data clinical record lacked re-assessment to develop re plan to promote healing of ent infections and/or further o the alterations in her skin 10 p.m. the director of nursing 09's clinical record and	F	809			2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
F 314 SS=D	verified a comprehe lacking. 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoidal pressure sores rece	ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores essure sores unless the condition demonstrates that ble; and a resident having lives necessary treatment and healing, prevent infection and	F3	314	F314 It is the policy of Johanna Sho all residents receive a compressessment to ensure the prevof development of pressure so unless the individual's clinical condition demonstrates they we unavoidable. To ensure continuous compliance the following plant been implemented:	hensive vention vere vere nued has	11/13/12
The control of the co	by: Based on observative review, the facility fawas provided and a address repositioning.	on, interview and document illed to ensure repositioning care plan developed to g based on a comprehensive 3 residents (R53) in the			The care planning policy has be reviewed and remains accurate care plans are reviewed and us in conjunction with the RAI proinclude changes in condition.	e. All pdated	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		245424	B. WIN	NG		10/0	4/2012
	PROVIDER OR SUPPLIER		•	32	EET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	Findings include: R53 was not provirepositioning as decomprehensive sk three hours and 30 on 10/3/12. R53 had diagnose failure, pain in join disease, and peripannual Minimum Lindicated R53 was extensive assistant totally dependent Score (a tool used development) date mild risk for pressundated Compreh form indicated R53 repositioning while R53's care plan daidentified a probled diabetic ulcer on the coccin bed and with trainterventions indictor all transfers, ne bed mobility, and in the positioned on how for repositioned while	ded every two hour etermined by the in assessment and went for 5 minutes without repositioning s to include congestive heart t, diabetes, chronic kidney wheral vascular disease. The Data Set (MDS) dated 5/24/12, a cognitively intact, required lice with bed mobility and was for transfers. The Braden to predict pressure ulcer ed 5/18/12, was 15 indicating lure ulcer development. The ensive Skin Data Collection 3 required every two hour in bed and in the wheelchair. Ated as initiated on 5/25/12, m with skin integrity related to a ne toe, two stage two pressure lyx, and a problem with mobility insfers. The care plan lacked eded extensive assistance with dentified the resident refused to er sides. The care plan lacked requently R53 required to be in bed or in the wheelchair and as to address R53's	F	314	A comprehensive re-assessment fesident 53 was completed to repositioning needs. Based assessment results a reposition was developed and document resident #53's care plan. All rewith current skin conditions have reviewed and reassessed as a reviewed and planning policy was provided. Household staff during the wealth 10/15/12/and again 10/29/12. Random audits will be completed weekly for 4 weeks and month months to ensure accurate development and completion plans based on assessment of Audits will be reviewed at QA for direction or change if neonand determine if continuation is needed based on compliant results. The Clinical Administrator and designee are responsible for compliance. Date certain for ongoing com 11/13/2012.	identify on on plan ted on esidents ave been needed. It the care for all tek of eted hly for 2 of care lata. meeting essary of audits nce ad/or ongoing	2012 VED 2013 VOI

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'') MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETI			
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	ROVIDER OR SUPPLIER	ARDEN HILLS		32	ET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		(((((((((((((((((((
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	On 10/3/12, at 7:15 seated in a wheelch house dress. At the been up for awhile with getting out of its stated her lower leg wounds on the butt the wheelchair in hea.m., the resident wroom. At approximathe dining area, R5 medications. R53 remained in the whole television. At 10:2 light and notified standard activity. The activity in the diremained at the activity in the diremained at the activity. The activity in the diremained at the activity of the activity. The activity in the diremained at the activity at 10:4 (NA)-C stated R53 wheelchair when head the wheelchair. Note the wheelchair. Note the wheelchair. Note the wheelchair when she confirmed R53 had least three (3) hour On 10/4/12, at 10:3 (CM)-C stated R53 non-compliant with the current care plareposition R53 and repositioned. CM-have been updated should have repositioned.	is a.m. R53 was observed to be hair in her room and wearing a at time, R53 stated she had and needed staff assistance bed and with dressing. R53 gs would weep and she had locks. R53 remained seated in er room until 8:00 a.m. At 8:00 was wheeled to the dining lately 9:00 a.m., after leaving 3 received her morning went back to her room, eelchair and watched 7 a.m., R53 put on the call laff she wanted to attend a The staff nurse took R53 to ining room at 10:35 a.m R53 tivity in the dining room and ed to a.m. the nursing assistant was already up in the errived for the morning shift. Sisted R53 with morning cares had not repositioned R53 out of A-C stated the resident could needed to use the toilet and not been repositioned for at a sand 35 minutes. So a.m. the clinical manager could sometimes be repositioning. CM-C verified an lacked direction to lacked R53's refusals to be C stated the care plan should and the nursing assistant tioned R53 every two hours.		314			2012 AVED - 9391
F 329 SS=D	483.25(I) DRUG RE UNNECESSARY D	EGIMEN IS FREE FROM PRUGS	F-1	329	•		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DATE S COMPLI	
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(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
Continued From page	age 21	FS	329	F329		11/13/13
unnecessary drugs drug when used in duplicate therapy); without adequate r indications for its unadverse conseque should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessars diagnosed and record; and reside drugs receive grad behavioral interver	excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose or discontinued; or any e reasons above. The ensure that residents and antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical ents who use antipsychotic drug dual dose reductions, and entions, unless clinically			each resident's drug regime from unnecessary drugs. To continued compliance the for plan has been implemented. The Psychotropic medication has been reviewed and updereflect attempts and docume efficacy of non pharmalogical interventions prior to giving psychoactive medications. The pharmacist consultant residents monthly. Recomm for resident 197's drug regimented. Staff update the MAF plan to reflect appropriate to behaviors and non pharmalogical.	n is free ensure ensure ellowing : n policy ated to entation of al prn reviews all nendations men were R and care arget ogical	22 (A.D.)
by: Based on interview facility failed to ensinterventions were clinical indications implemented for 1	w and document review, the sure non-pharmacological developed and monitoring of and side effects were of 4 residents (R197) whose			10/29/12 staff were re-eductive revised policy to include use pharmalogical interventions documentation of efficacy p	ated on e of non and rior to	
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR IT) Continued From particular designation of the unnecessary drugs drug when used in duplicate therapy); without adequate rindications for its unadverse conseques should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessarian as diagnosed and record; and resided drugs receive graded behavioral interver contraindicated, in drugs. This REQUIREME by: Based on interview facility failed to ensinterventions were clinical indications implemented for 1 medication regime	PROVIDER OR SUPPLIER TERIAN HOMES OF ARDEN HILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were developed and monitoring of clinical indications and side effects were implemented for 1 of 4 residents (R197) whose medication regimen was reviewed.	PROVIDER OR SUPPLIER TERIAN HOMES OF ARDEN HILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were developed and monitoring of clinical indications and side effects were implemented for 1 of 4 residents (R197) whose medication regimen was reviewed.	TERIAN HOMES OF ARDEN HILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drug are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drug therapy is necessary to treat a specific condition as diagnosed interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were developed and monitoring of clinical indications and side effects were implemented for 1 of 4 residents (R197) whose medication regimen was reviewed.	PROVIDER OR SUPPLIER TERIAN HOMES OF ARDEN HILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drugs are not given these drugs unless entipsychotic drugs are not given these drugs unless entipsychotic drugs are not given these drugs unless entipsychotic drugs are not given these drugs. This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were developed and monitoring of clinical indications and side effects were implemented for 1 of 4 residents (R197) whose medications.	TERIAN HOMES OF ARDEN HILLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY THE REDULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration, or without adequate monitoring, or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record, and residents who use antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record, and residents who use antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record, and residents who use antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record, and residents who use antipsychotic drugs are not given these drugs unless antipsychotic drugs are not given these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions for all residents as part of the RAI process. During the week of 10/22/12 and again 10/29/12 staff were re-educated on revised policy to include use of non pharmalogical interventions and documentation of efficacy prior to administering prin psychoactive medications.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		245424	B. WI	۷G		10/0	4/2012
	ROVIDER OR SUPPLIER	ARDEN HILLS		32	EET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
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F 329	R197 was admitted with diagnoses to in behavioral disturba generalized muscled disorder. The annuassessment dated cognitive impairment mood symptoms. R10/1/12, directed to a short acting benz treat acute anxiety) hour prior to weekly "anxiety" and one to six hours since 11/2. The Psychotherape 6/19/12, identified F "anxiety with bath" indicated the target occasionally wands worries about car 8 the behaviors were previous quarter. The Neview dated 9/4/1 lorazepam was undwere listed as, "Somoving home. Infres belongings." The mere "unchanged" The Medication Addated from 6/24/12 R197 was administ and 10/3/12, due to behaviors of "anxiosaying she's going on the MAR were "	to the facility on 11/15/10, nolude dementia without noces, difficulty walking, weakness, and depressive all Minimum Data Set (MDS) 9/05/12, identified R197 had nt, delusional behaviors and a197's physician's orders dated administer lorazepam (Ativan, odiazepine medication used to 0.5 milligrams (mg) half and baths for the diagnosis of ablet as needed (PRN) every	F:	329	Random audits will be comple weekly for 4 weeks and month months to ensure accurate documentations of attempts at efficacy of non pharmalogical interventions. Audits will be reat QA meeting for direction or if necessary and determine if continuation of audits is needed on compliance results. The Clinical Administrator and designee are responsible for compliance. Date certain for ongoing compliance. Date certain for ongoing compliance.	nly for 2 and eviewed change ed based d/or ongoing	

7.37

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ARDEN HILLS		3	REET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112		
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F 329	staff offered these a were left blank. The of each target behaviors were exhon-pharmacologic prior to the adminis efficacy of the interclinical record lacked what types of anxio by R197 prior to or what non-pharmacolattempted and the results of the staff of the sta	approaches and the results e MAR lacked documentation vior to establish which target	F	3329			2012 2012 2020 20301
	(RN)-C reviewed th records and verified weekly and PRN sir confirmed the clinic documentation regal behaviors, if non-phwere attempted and potentially minimize Ativan. RN-C state on Wednesdays and documented what sexhibited, which not	arding daily monitoring of parmacological interventions. It side-effect monitoring to or eliminate the use of the d R197 received baths weekly d the staff should have pecific behaviors were n-pharmacological attempted to address the					\$20.05 \$2.00
	dated as revised on resident's drug regin unnecessary drugs, drug when used with	n Psychotropic medication use 11/20/11, indicated, "Each men must be free from Unnecessary drugs are any hout adequate monitoring, dications for its use" The			•		1994 1994

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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F 329.	policy indicated, "7. licensed nurses, ce activity therapists, s members) will moni	Facility staff (such as ertified nursing assistants, social workers, and other staff itor the resident's medical on, circumstances and	F;	329			
	appropriateness of being used." The p staff will monitor for psychoactive medic behaviors and the " side-effects." The p non-pharmacological	the psychoactive medication policy further directed facility					. (1999)
F 428 SS=D	medications. 483.60(c) DRUG RI	EGIMEN REVIEW, REPORT	F	428			7 (A) (4) (4) (4) (4) (5) (4) (7)
		of each resident must be nce a month by a licensed					, 1 (siq.
	the attending physic	ist report any irregularities to cian, and the director of reports must be acted upon.					
A control of the cont	by: Based on interview facility's consultant the lack of non-phar monitoring for clinica	NT is not met as evidenced and document review, the pharmacist failed to ensure rmacological interventions, all indications and side effect was identified and reported (R197).					. 117 14 45 131 131

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER/CLIA (X3) DATE SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER/CLIA (X3) DATE SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X5) DATE SUPPLIER/CLIA (X6) MULTIPLE CONSTRUCTION (X6) DATE SUPPLIER/CLIA (X6)						
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F 428	Findings include: R197 received Ative benzodiazepine mention half an hour prior to the clinical record development of no interventions, monuse of the medicat side-effects related	van (a short acting edication) 0.5 milligrams (mg) o weekly baths; and as needed burs for anxiety since 11/11/11. lacked documentation and	F.	428	It is the policy of Johanna Shoreach resident's drug regimen is reviewed at least monthly by a licensed pharmacist. The Psychotropic medication phas been reviewed and update reflect staff attempts and documentation of efficacy of not pharmalogical interventions prigiving prin psychoactive medical.	olicy d to on or to ations.	11/13/12
	with diagnoses to ibehavioral disturbate generalized muscle disorder. The annuassessment dated cognitive impairmed mood symptoms. The Medication Act dated from 6/24/12 R197 was administed and 10/3/12, due to behaviors of "anxious aying she's going on the MAR were however, the docustaff offered these were left blank. The of each target behaviors were expended to the administed of the administed for the interest of the interest of the service of the se	Include dementia without ances, difficulty walking, e weakness, and depressive ual Minimum Data Set (MDS) 9/05/12, identified R197 had ent, delusional behaviors and deministration Record (MAR) 2, through 10/23/12, indicated tered PRN Ativan on 6/25/12, to exhibiting the clustered target bus, wandering, packing, home." The approaches listed 'redirect" and "activity" mentation whether the facility approaches and the results ne MAR lacked documentation avior to establish which target			The pharmacist consultant reviresidents monthly. The pharmaconsultant has reviewed and precommendations for resident drug regimen. Staff update the and care plan to reflect approprarget behaviors and non pharmalogical interventions for residents as part of the RAI produced by the produced provided the revised policy to include use of pharmalogical interventions and documentation of efficacy prior administering prn psychoactive medications. Staff were re-educed on role of consultant pharmacis review resident drug regimen's minimally on a monthly basis a provide recommendations for cas appropriate.	acist rovided 197's MAR riate all ocess. ad again d on non d to classed st to	

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F 428	by R197 prior to or what non-pharmaco attempted and the reduce or eliminal Ativan. On 10/04/12, at 1:3 (RN)-C reviewed the records and verified weekly and PRN sinconfirmed the clinic documentation regabehaviors, if non-phwere attempted and potentially minimized Ativan. RN-C state on Wednesdays and documented what sexhibited, which no interventions were attarget behaviors an interventions.	us behaviors were exhibited during the bathing activity; plogical interventions were results of these interventions ate the use of the weekly 5 p.m. the clinical coordinator e electronic and paper clinical R197 had received Ativan nce 11/11/11. RN-C al record lacked arding daily monitoring of narmacological interventions diside-effect monitoring to e or eliminate the use of the d R197 received baths weekly did the staff should have specific behaviors were	F.	428	Random audits will be completed weekly for 4 weeks and mont months to ensure accurate documentations of attempts a efficacy of non pharmalogical interventions. Audits will be reat QA meeting for direction or if necessary and determine if continuation of audits is need on compliance results. The Clinical Administrator and designee are responsible for ecompliance. Date certain for ongoing company 11/13/2012.	hly for 2 and eviewed change ed based d/or ongoing	-2012 -2012 -2013
	Physician form date received "Ativan 0.8 Although the form of boxes for the physician dosage reduction. lack of monitoring fron-pharmacologic	ed 9/25/12, identified R197 of mg weekly before bath." offered suggested check cian to select for a potential The form did not identify the or efficacy, al interventions, monitoring for e monitoring of target					27.12 27.12 27.10 27.80
·	pharmacist (CS) sta	0 p.m. the consultant ated he was fairly new to the ne needed to "review" R197's			•		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00975

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LDING	CONSTRUCTION	COMPL	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	records to obtain ar would "fax it in for not CS stated the nursi behaviors, psychotr non-pharmacologic stated he reviewed and if incomplete, the to the director of nurside the director of nurside the director of nursident's Psychological dated as revised on resident's drug reging unnecessary drugs, drug when used without adequate in policy further director on a monthly basis for the drug use and reductions or modifications or modification control pressed, sanitary and control pressed and infection control pressed and	ny pertinent information and eview on Monday, 10/15/12." ng staff needed to monitor ropic medication use and offer al interventions. He further this data on a monthly basis hen reported the irregularities irsing and MD. otropic Medication Use policy 11/2011, directed, "Each men must be free from Unnecessary drugs are any chout adequate monitoring, idications for its use" The ed, "12. The Pharmacy we resident medication records for documentation/justification d will recommend dosage ications as appropriate." 10 p.m. no further information in CONTROL, PREVENT tablish and maintain an orgam designed to provide a comfortable environment and development and transmission oction. I Program tablish an Infection Control		141			2012 2.040 2.050 2
	(2) Decides what pr	ocedures, such as isolation,					4.41

			3) DATE SURVEY COMPLETED				
		245424	B. WI	√G_		10/0	4/2012
	ROVIDER OR SUPPLIER	ARDEN HILLS		3:	EET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		13 (39)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	should be applied (3) Maintains a recactions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable disc from direct contact will treat contact will treat contact will treat and washing is in professional practic (c) Linens Personnel must hat transport linens so infection. This REQUIREME by: Based on observation review, the facility control measures of handling soiled dreat removing soiled glospread of infection R148) observed for Findings include:	to an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program resident needs isolation to of infection, the facility must it prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted		441	It is the policy of Johanna Shorensure Infection Control practiful followed to minimize risk and sinfection. To ensure continued compliance the following plant been implemented: The facility policy on Infection has been reviewed and remain accurate. The facility maintain infection control program to he prevent the development and transmission of disease and in The facility policy on pressure was reviewed and remains accurate was reviewed and remains accurate. Staff were re-educated on propinfection control procedures rewound treatments for resident resident 148. Staff were re-educated on proper hand washing techniclean maintenance of supplies equipment and proper disposal contaminated equipment durin week of 10/15/12 and 10/22/12. Random audits of proper hand washing, maintenance of infection equipment, containers and supplies equipment.	ces are spread of d has control ins s an elip fection. ulcers curate. cer lated to 53 and ucated iques, and I of g the 2 ction free	11/13/12
	1.00 Has not provid	and broken uneasing and					<u>:</u>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245424	B. WII	1G		10/0)4/2012
	PROVIDER OR SUPPLIER			32	EET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPERTY)	ULD BE	(X5) COMPLETION DATE
F 441	methods during a registered nurse (lafter handling soile hands before application open coccyx wour On 10/3/12, at application open coccyx wour On 10/3/12, at application open coccyx wour of the soiled the wand left ischeal are would need to be assistants then laightered the necestres the wounds gloves and removersident's coccyx wounds were obscolored matter on remove the gloves dressings. RN-C wet wipes out of the soiled gloves apetroleum based of the areas were retegaderm product RN-C cleansed the dressing, then picklisposed of them then removed the dressing supplies, room. After disposerved to wash room. At the time verified she did not seem of the soiled she did not seem of the see	dressing change. The RN)-C did not change gloves ed dressings, or wash her lying a clean dressing to an	F	441	will be done weekly for one more monthly for 2 months. Audits we reviewed at QA meeting for direction or change if necessary and designed on compliance results. The Clinical Administrator and designed are responsible for occumpliance. Date certain for the purpose of compliance is 11/13/2012	rill be ection termine ded /or	

6, 37

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE S COMPL	
		245424	B. WIN	IG		10/	04/2012
	PROVIDER OR SUPPLIER	ARDEN HILLS		322	ET ADDRESS, CITY, STATE, ZIP COD	PΕ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Gloves and washed On 10/3/12, at 8:18 -B was observed to morning cares. At 8 due to R148 inconti (BM). Upon turning was observed on the gloves after peri car Donned another paperi care. NA-A rem washing hands wer the nurse to report registered nurse (R set a container of s bedside stand. With donned a pair of gloves after peri care. NA-A rem washing hands were the nurse to report registered nurse (R set a container of s bedside stand. With donned a pair of gloves and donned a pair of gloves and grades. RN-A removed the washing hands, dor cleanse the three of them reached into a dressings, and grade areas. RN-A was old dressing package at the same soiled glowound spray to the three Allevyn dressing kn-A took a marked the date on returned the marker removed gloves and on a fresh pair of clessing bin looking dressing bin looking gloves and gressing bin looking dressing bin looking gloves and gressing bin looking gloves and glov	ed she should have changed	F	41			20 20 27 20

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIP ILDING	LE CONSTRUCTION	(X3) DATE 5 COMPL	
		245424	B. Wi	NG		10/0	04/2012
	PROVIDER OR SUPPLIER	ARDEN HILLS		32	EET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		:485 :257
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	gloves and proceed the uniform pocket wash her hands. R friction for seven se retrieved the suppli- removed gloves, di another pair of fresh	led to answer the cell phone in while walking to the sink to N-A lathered with soap and econds, dried her hands and es to leave the room. NA-B id not wash hands and put on higher gloves to dress R148.	F	441			. voi2
	(DON) verified staff hands between glov gloves before hand	0 p.m. the director of nursing should have washed their we use and removed the soiled ling clean supplies and items.					1391
•	Policy/Procedure da "Hand hygiene mus blood, body fluids, sitems, whether or nimmediately after glotherwise indicated microorganisms to equipment and/or the Policy and Procedu "#12. Put on exam gremove dressing. #	ated August 2003 indicated, at be performed after touching secretions, and contaminated of gloves are worn; oves are removed, and when to avoid transfer of other residents, personnel, ne environment." The Ulcer re dated 10/2/12, directed, glove. Loosen tape and 13. Pull glove over dressing to bag. Wash hands. #14. Put on		A STATE OF THE PROPERTY OF THE STATE OF THE			VE 0
							1612 - 302 - 321

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION O1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 10/02/2012	
	245424		B. WIN	NG			
NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF ARDEN HILLS				32	EET ADDRESS, CITY, STATE, ZIP CODE 20 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	I .	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	building with a full I constructed at 2 dir building was constructed to be of 2006, an addition with side of the building Type II(222) construction codes two separate building. The building is fully facility has a composmoke detection in open to the corridor automatic fire departments of 205 at the construction codes two separates as a licensed cap census of 205 at the construction codes.	e of Arden Hills is a 4-story pasement. The building was fferent times. The original ructed in 1978 and was f Type II(222) construction. In was constructed to the West that was determined to be of ruction. Because the original Idition are of 2 different the facility was surveyed as ngs. If sprinkler protected. The lete fire alarm system with the corridors and spaces r, that is monitored for artment notification. The facility acity of 208 beds and had a net time of the survey. If 42 CFR Subpart 483.70(a) is	K	000			
ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G 02 - 2006 ADDITION	(X3) DATE SURVEY COMPLETED	
		245424	B. WI	NG _		10/0	2/2012
NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF ARDEN HILLS				3	REET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Presbyterian Home of Arden Hills is a 4-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type II(222) construction. In 2006, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the addition are of 2 different construction codes the facility was surveyed as two separate buildings. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 208 beds and had a census of 205 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET. *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.		K	000			
I ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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