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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZGRT

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/21/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **208** (L18)

13.Total Certified Beds **208** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IMR |
|---|---|---|---|---|
| | 208 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 11/26/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/05/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**02/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 12/18/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**11/20/2012**
(L33)

DETERMINATION APPROVAL

**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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*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

## Post-Certification Revisit Report



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245424 | A. Building<br>B. Wing | 11/21/2012 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PRESBYTERIAN HOMES OF ARDEN HILLS | 3220 LAKE JOHANNA BOULEVARD<br>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 **F0225**<br>Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)**<br>LSC | Correction Completed **11/13/2012** | ID Prefix **F0226**<br>Reg. # **483.13(c)**<br>LSC | Correction Completed **11/13/2012** | ID Prefix **F0274**<br>Reg. # **483.20(b)(2)(ii)**<br>LSC | Correction Completed **11/13/2012** |
| ID Prefix **F0279**<br>Reg. # **483.20(d), 483.20(k)(1)**<br>LSC | Correction Completed **11/13/2012** | ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **11/13/2012** | ID Prefix **F0314**<br>Reg. # **483.25(c)**<br>LSC | Correction Completed **11/13/2012** |
| ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | Correction Completed **11/13/2012** | ID Prefix **F0428**<br>Reg. # **483.60(c)**<br>LSC | Correction Completed **11/13/2012** | ID Prefix **F0441**<br>Reg. # **483.65**<br>LSC | Correction Completed **11/13/2012** |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | SR/sd | 11/26/12 | 16022 | 11/21/12 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 10/4/2012 | | | |

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZGRT

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00975

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/04/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **208** (L18)

13.Total Certified Beds **208** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IMR |
|---|---|---|---|---|
| | 208 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Vidya Tomar, HFE NE II 10/30/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 11/14/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**02/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 11/20/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

**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.

MINNESOTA MDH DEPARTMENT OF HEALTH

*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;**

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

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

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

**DEPARTMENT CONTACT**

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

Susanne Reuss
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/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:

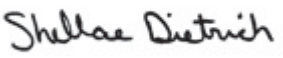
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245424 | A. BUILDING _____ B. WING _____ | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRESBYTERIAN HOMES OF ARDEN HILLS | 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. | F 000 | Recieved 10/29/12 | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the | F 225 | F225<br><br>It is the policy of Johanna Shores that all allegations of mistreatment, neglect or abuse are immediately reported to the administrator and thoroughly investigated. To ensure continued compliance the following plan has been implemented:<br><br>The Vulnerable Adult Policy was reviewed and remains accurate. Likko lift transfer policy was reviewed and remains accurate.<br><br>Fact finding investigation of resident 131's allegations was investigated upon notification by surveyor. VA has 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 resident 131's and resident 53's allegations of abuse were reviewed and investigative findings and interventions were sent to OHFC with no further action necessary. | 11/13/12 |

10/30/12 SER

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Risa Ann Kalle — TITLE: Administrator — (X6) DATE: 10/29/12

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245424 | A. BUILDING _____ B. WING _____ | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PRESBYTERIAN HOMES OF ARDEN HILLS | 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 |

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| F 225 | Continued From page 1<br>State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the administrator for 1 of 4 residents (R131) reviewed for allegations of abuse; in addition, the facility failed to ensure allegations of mistreatment were reported to the State Agency (SA) for 2 of 4 residents (R53, R131) reviewed for allegations of mistreatment.<br><br>Findings include:<br><br>The facility failed to immediately report R131's allegations of rough treatment to the administrator and SA.<br><br>On 10/2/12, at 11:27 a.m. R131 stated nursing assistants had taken her call light away at times during the day shift and approximately one month ago, nursing assistants placed her in the sling of | F 225 | Re-Education of the Vulnerable Adult Policy was provided to all staff during the week of10/15/12 and 10/22/12 to include documentation of timely notification of the administrator and immediate reporting to state agency.<br><br>Random audits will be completed weekly for 4 weeks and monthly for 2 months to ensure documentation of timely notification of administrator and immediate or asap reports to state agency . Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits is needed based on compliance results.<br><br>The Administrator and/or designee are responsible for ongoing compliance.<br><br>Date certain for ongoing compliance is 11/13/2012 | |

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| F 225 | Continued From page 2<br>a mechanical lift and left her "hanging over" her bed for roughly a half an hour. R131 also stated staff had placed soaker pads on her bed at night in a formation which created a lump under her body. R131 stated when she asked staff to adjust the soaker pads, staff laughed at her. R131 stated she reported these incidents to the household coordinator (HC)-B, but HC-B had not resolved the concerns. R131 then explained she was afraid to ask staff for anything because she no longer felt staff believed her or cared about her.<br><br>R131's diagnoses included depression, macular degeneration, left eye blindness and stroke. The Brief Interview for Mental Status (BIMS, a tool used to help in evaluating cognitive function) dated 8/22/12, indicated R131 was cognitively intact. R131's Minimum Data Set (MDS) dated 8/22/12, noted no symptoms of psychosis such as hallucinations or delusions were present. The September and October 2012 target behavior monitoring for all three shifts indicated R131 displayed no evidence of "delusions - false fixed object." The interdisciplinary staff Progress Notes dated 9/1/12, to 10/4/12, indicated no evidence of psychosis or confusion was displayed by R131. The care plan dated 12/31/11, indicated R131 had a history of falls and directed staff to use the "full lift" for transfers in and out of bed.<br><br>During a follow up interview on 10/3/12, at 1:41 p.m. R131 again reported staff "strung [her] up" in a mechanical lift after a bath. R131 was unsure of when the incident occurred, but believed it was in September. R131 stated an older nursing assistant (identity unknown) frequently took her call light away, placed soaker pads underneath | F 225 | | |

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| F 225 | Continued From page 3 | F 225 | | |

her in a way which was uncomfortable, and used her fingernails to "dig" into R131 during a bath. R131 also recounted an incident which occurred about two weeks ago, when staff did not close the privacy curtain while her roommate had guests in the room. R131 reported she was not clothed and was "humiliated." R131 added, "I know I am old, but darn I don't deserve that." R131 stated she told the HC-B about the call light concerns approximately three weeks ago, but the issue was not resolved. R131 stated she told two different male staff members (identity unknown) about the other concerns.

On 10/3/12, at 2:25 p.m. HC-B stated R131 had not informed her of any concerns about staff members. HC-B stated, she "can speak with {R131} so she feels like it is followed up on." After HC-B was informed of all of R131's above listed allegations, HC-B stated R131 had a history of "seeing things that aren't there."

On 10/4/12, at 10:27 a.m. the administrator stated HC-B had reported R131 made allegations staff were "mean to her," this morning between 9:00 a.m. and 9:30 a.m. The administrator stated R131's description of the alleged perpetrator and allegations had been "confusing" and the facility was trying to get a better description of the alleged perpetrator and allegations. The administrator stated staff usually brought concerns about mistreatment to her immediately, but since the facility believed R131 was "delusional," they were going to investigate.

At 10:36 a.m. HC-B stated she interviewed R131 on the morning of 10/4/12 because R131 was resting when she tried to interview her last night.

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| F 225 | Continued From page 4<br>HC-B stated R131 described being in a "cage like lift" for over thirty minutes and had difficulty identifying staff members. HC-B stated she told the director of nursing about R131's concerns at approximately 3:00 p.m. on 10/3/12.<br><br>At 10:45 a.m. the administrator again confirmed she did not know about R131's concerns until approximately 9:30 a.m. on 10/4/12 (approximately 19 hours after the surveyor informed HC-B of R131's allegations). The administrator stated " it was about being in a cage and left in bed over an hour, can't remember everything else". The administrator confirmed the facility had not reported the incident to the SA. At 11:15 a.m. the administrator stated the facility "can't substantiate abuse" regarding R131's allegations because the facility believed they were delusional and R131 was diagnosed with "senile dementia." On 10/4/12, at 12:00 p.m. the administrator stated the facility did not agree R131's allegations needed to be immediately reported to the SA, because the facility believed the allegations were based on delusions. The administrator stated she believed a report needed to be made to the SA within 24-hours of an allegation being made.<br><br>The facility failed to report R53's allegations of verbal abuse immediately to the SA.<br><br>R53's diagnoses included congestive heart failure, hypertension and a personal history of falls. The care area assessment (CAA) dated 5/30/12, indicated R53 was cognitively aware of her safety needs and able to use the call light | F 225 | | |

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| F 225 | Continued From page 5<br>consistently to call for assistance.<br><br>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).<br><br>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 up...You just went to bed..." and "I am not going waste time putting you to bed and then getting you up..."<br><br>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 morning on 9/9/12.<br><br>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 regulations, it is the policy of Presbyterian Homes | F 225 | | |

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| F 225 | Continued From page 6<br>and Services to require reporting of the maltreatment of adult residents, who are rendered vulnerable by reason of physical or mental disability, are relying on the institution for provision of care and are deemed to be unable or unwilling to report such treatment of their own accord."; "Internal Investigative Steps: ... I. State Agency: Immediately make a report to the State Agency."<br><br>On 10/4/12, at 12:00 p.m. the administrator stated she believed a report needed to be made to the SA within 24-hours of an allegation being made. | F 225 | | |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement their abuse prohibition policy regarding immediately reporting allegations of rough treatment to the administrator for 1 of 4 residents (R131); in addition, the facility failed to implement the policy by immediately reporting allegations of mistreatment to the State Agency (SA) for 2 of 4 residents (R53, R131) reviewed for abuse prohibition.<br><br>Findings include: | F 226 | F226<br><br>It is the policy of Johanna Shores that all allegations of mistreatment, neglect or abuse are immediately reported to the administrator and thoroughly investigated. To ensure continued compliance the following plan has been implemented:<br><br>The Vulnerable Adult Policy was reviewed and remains accurate. Likko lift transfer policy was reviewed and remains accurate. | |

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| F 226 | Continued From page 7<br>The Vulnerable Adult Abuse Prevention Plan dated as updated April 2012 directed, "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 regulations, it is the policy of Presbyterian Homes and Services to require reporting of the maltreatment of adult residents, who are rendered vulnerable by reason of physical or mental disability, are relying on the institution for provision of care and are deemed to be unable or unwilling to report such treatment of their own accord."; "Internal Investigative Steps: ... I. State Agency: Immediately make a report to the State Agency."<br><br>The facility failed to implement their abuse prohibition policy regarding immediately reporting allegations of rough treatment (mistreatment/maltreatment) to the administrator and State Agency for R131.<br><br>On 10/2/12, at 11:27 a.m. R131 stated nursing assistants had taken her call light away at times during the day shift and approximately one month ago, nursing assistants placed her in the sling of a mechanical lift and left her "hanging over" her bed for roughly a half an hour. R131 also stated staff had placed soaker pads on her bed at night in a formation which created a lump under her body. R131 stated when she asked staff to adjust the soaker pads, staff laughed at her. R131 stated she reported these incidents to the household coordinator (HC)-B, but HC-B had not | F 226 | Fact finding investigation of resident 131's allegations was investigated upon notification by surveyor. VA has 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 resident 131's and resident 53's allegations of abuse were reviewed and investigative findings and interventions were sent to OHFC with no further action necessary.<br><br>Re-Education of the Vulnerable Adult Policy was provided to all staff during the week of10/15/12 and 10/22/12 to include documentation of timely notification of the administrator and immediate reporting to state agency.<br><br>Random audits will be completed weekly for 4 weeks and monthly for 2 months to ensure documentation of timely notification of administrator and immediate or asap reports to state agency . Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits is needed based on compliance results. | |

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| F 226 | Continued From page 8<br>resolved the concerns. R131 then explained she was afraid to ask staff for anything because she no longer felt staff believed her or cared about her.<br><br>During a follow up interview on 10/3/12, at 1:41 p.m. R131 again reported staff "strung [her] up" in a mechanical lift after a bath. R131 was unsure of when the incident occurred, but believed it was in September. R131 stated an older nursing assistant (identity unknown) frequently took her call light away, placed soaker pads underneath her in a way which was uncomfortable, and used her fingernails to "dig" into R131 during a bath. R131 also recounted an incident which occurred about two weeks ago, when staff did not close the privacy curtain while her roommate had guests in the room. R131 reported she was not clothed and was "humiliated." R131 added, "I know I am old, but darn I don't deserve that." R131 stated she told the HC-B about the call light concerns approximately three weeks ago, but the issue was not resolved. R131 stated she told two different male staff members (identity unknown) about the other concerns.<br><br>On 10/3/12, at 2:25 p.m. HC-B stated R131 had not informed her of any concerns about staff members. HC-B stated, she "can speak with {R131} so she feels like it is followed up on." After HC-B was informed of all of R131's above listed allegations, HC-B stated R131 had a history of "seeing things that aren't there."<br><br>On 10/4/12, at 10:27 a.m. the administrator stated HC-B had reported R131 made allegations staff were "mean to her," this morning between 9:00 a.m. and 9:30 a.m.. The administrator stated | F 226 | The Administrator and/or designee are responsible for ongoing compliance.<br><br>Date certain for ongoing compliance is 11/13/2012 | |

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| F 226 | Continued From page 9<br>R131's description of the alleged perpetrator and allegations had been "confusing" and the facility was trying to get a better description of the alleged perpetrator and allegations. The administrator stated staff usually brought concerns about mistreatment to her immediately, but since the facility believed R131 was "delusional," they were going to investigate.<br><br>At 10:36 a.m. HC-B stated she interviewed R131 on the morning of 10/4/12 because R131 was resting when she tried to interview her last night. HC-B stated R131 described being in a "cage like lift" for over thirty minutes and had difficulty identifying staff members. HC-B stated she told the director of nursing about R131's concerns at approximately 3:00 p.m. on 10/3/12.<br><br>At 10:45 a.m. the administrator again confirmed she did not know about R131's concerns until approximately 9:30 a.m. on 10/4/12 (approximately 19 hours after the surveyor informed HC-B of R131's allegations). The administrator stated "it was about being in a cage and left in bed over an hour, cant remember everything else" The administrator confirmed the facility had not reported the incident to the SA. At 11:15 a.m. the administrator stated the facility "can't substantiate abuse" regarding R131's allegations because the facility believed they were delusional and R131 was diagnosed with "senile dementia." On 10/4/12, at 12:00 p.m. the administrator stated the facility did not agree R131's allegations needed to be immediately reported to the SA, because the facility believed the allegations were based on delusions. The administrator stated she believed a report needed to be made to the SA within 24-hours of an | F 226 | | |

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| F 226 | Continued From page 10<br>allegation being made.<br><br>The facility failed to implement their abuse prevention policy and report R53's allegations of verbal abuse immediately to the SA.<br><br>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 system 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).<br><br>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 up...You just went to bed..." and "I am not going waste time putting you to bed and then getting you up..."<br><br>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 morning on 9/9/12.<br><br>On 10/4/12, at 12:00 p.m. the administrator stated she believed a report needed to be made to the SA within 24-hours of an allegation being made. | F 226 | | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE | F 274 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 274 | Continued From page 11<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview the facility failed to complete a significant change assessment for 1 of 3 residents (R109) in the sample after development of blisters on the thighs.<br><br>Findings include:<br><br>R109 developed fluid filled blisters on bilateral thighs and was not provided a re-assessed of these changes.<br><br>R109 was admitted on 6/1/12, with diagnoses to include congestive heart failure, a blister on top of the right foot, leg weakness and swelling, Deep Vein Thrombosis (DVT), Diabetes Mellitus and was on a palliative care focused plan of care. R109 died on 09/12/12 at the facility. | F 274 | F 274<br><br>It is the policy of Johanna Shores that each resident has a comprehensive assessment with in 14 days of significant change of condition to develop a plan that meets the needs of each resident and ensures their physical, mental and psychosocial well being. To ensure continued compliance the following plan has been implemented:<br><br>The policy for completion of MDS related assessment known as the Skin Risk Policy was reviewed and remains appropriate.<br><br>Resident 109 is no longer in our facility.<br><br>Residents are assessed for comprehensive skin conditions upon admission, with a new unset of a skin condition and with any significant change in condition in conjunction with the RAI process. All residents with current skin conditions have been reviewed and reassessed as needed.<br><br>Re-education for household staff in regards to Comprehensive Skin Assessment policy to include accurate documentation of all skin conditions was provided during the week of 10/15/12/ and again 10/29/12 | 11/13/12 |

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| F 274 | Continued From page 12<br>A significant change Minimum Data Set (MDS) assessment dated 8/27/12, identified R109 as having cognitive and memory impairments; required extensive assistance from staff with all activities of daily living (ADL) including transfers and used a wheelchair for mobility. The MDS indicated R109 was at risk for developing pressure ulcers and did not have any pressure ulcers, nor any venous or arterial ulcers. The associated Care Area Assessment (CAA) dated 08/27/12, indicated R109's health status had declined and was receiving hospice services. The CAA indicated R109 was at risk for skin alteration due to impaired physical mobility, non-weight bearing status, needing staff assistance with all ADLs and was repositioned every two hours.<br><br>R109's Braden Scale (a tool used for predicting pressure sore risk) dated 06/01/12, identified R109 as being at a mild risk for skin break-down. The correlating Skin Risk Data Collection form indicated R109 had a opened blister on top of the right foot and was at mild risk for skin breakdown. The Wound Assessment Flow Sheet dated 06/01/12, through 06/27/12, indicated the blister on top of right foot was healed.<br><br>The Weekly Bath Skin Assessment form dated 7/20/12, identified R109 had developed a 0.9 centimeter (cm) x 0.5 cm blister on the left front thigh; on 8/24/12, and 8/30/12, the forms identified R109 had "ruptured blisters, some intact" on the front and back of her bilateral thighs.<br><br>R109's temporary care plans dated 8/05/12, and 8/09/12, indicated R109 had a 3.0 cm by 1.5 cm | F 274 | Random audits will be completed weekly for 4 weeks and monthly for 2 months to ensure accurate documentation of skin conditions. Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits is needed based on compliance results.<br><br>The Clinical coordinator and/or designee are responsible for ongoing compliance.<br><br>Date certain for ongoing compliance is 11/13/2012. | |

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| F 274 | Continued From page 13<br>open blister on the right inner knee and blisters on the bilateral thighs, "(One in the front of each thigh)-NP (nurse practitioner) update."<br><br>A form titled "COMPREHENSIVE DATA COLLECTION" significant change dated 8/23/12, identified R109 had small open and fluid filled blisters on the bilateral upper thighs, "(back) & right front thigh." R109's Tissue Tolerance evaluation form (a tool used to determine repositioning needs) dated 08/23/12, indicated, "Skin intact, redness present and bleachable. Continue to reposition as CP (care plan)." The staff performing the skin evaluation failed to document the multiple blisters on R109's upper thighs. Although staff had documented multiple open/closed blisters on the Comprehensive Data Collection form, the clinical record lacked evidence of any skin re-assessment to develop an individualized care plan to promote healing of these blisters, prevent infections and/or further complications due to the alterations in her skin condition.<br><br>On 10/04/12, at 12:10 p.m. the director of nursing (DON) reviewed R109's clinical record and verified a comprehensive re-assessment was lacking. | F 274 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's | F 279 | F279<br><br>It is the policy of Johanna Shores that each resident has a Comprehensive Care Plan developed based on individual assessment results. To ensure continued compliance the following plan has been implemented: | 11/13/12 |

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| F 279 | Continued From page 14<br>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to develop a care plan to address repositioning and refusals of repositioning for 1 of 3 residents (R53) reviewed with pressure ulcers.<br><br>Findings include:<br><br>R53 lacked a care plan which identified the frequency of repositioning and addressed R53's refusals to be repositioned.<br><br>R53 had diagnoses to include congestive heart failure, pain in joint, diabetes, chronic kidney disease, and peripheral vascular disease. The annual Minimum Data Set (MDS) dated 5/24/12, indicated R53 was cognitively intact, required extensive assistance with bed mobility and was totally dependent for transfers. The Braden Score (a tool used to predict pressure ulcer development) dated 5/18/12, was 15 indicating mild risk for pressure ulcer development. The | F 279 | The care planning policy has been reviewed and remains accurate. All care plans are reviewed and updated in conjunction with the RAI process to include changes in condition.<br><br>A comprehensive re-assessment of resident 53 was completed to identify repositioning needs. Based on assessment results a reposition plan was developed and documented on resident #53's care plan.<br><br>Re-education on developing a comprehensive care plan and the care planning policy was provided for all Household staff during the week of 10/15/12 and again 10/29/12<br><br>Random audits will be completed weekly for 4 weeks and monthly for 2 months to ensure accurate development and completion of care<br><br>plans based on assessment data. Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits is needed based on compliance results. | |

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| F 279 | Continued From page 15<br>undated Comprehensive Skin Data Collection form indicated the resident was to be repositioned every two hours while in bed and/or in the wheelchair.<br><br>R53's care plan dated as initiated on 5/25/12, identified a problem with skin integrity related to diabetic ulcer on a toe, two stage two pressure ulcers on the coccyx, and a problem with mobility in bed and with transfers. The care plan interventions indicated R53 was totally dependent for all transfers, needed extensive assistance with bed mobility, and identified the resident refused to be positioned on her sides. The care plan lacked direction on how often R53 should have been repositioned while in bed or in the wheelchair and lacked interventions to address R53's refusals to reposition.<br><br>On 10/4/12, at 10:25 a.m. the clinical manager (CM)-C stated R53 could sometimes be non-compliant with repositioning. CM-C verified the current care plan lacked direction to reposition R53 and lacked interventions to address R53's refusals to be repositioned. CM-C stated the care plan should have been updated. | F 279 | The Clinical Administrator and/or designee are responsible for ongoing compliance.<br><br>Date certain for ongoing compliance is 11/13/2012. | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F 309 | | |

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| F 309 | Continued From page 16<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure residents with facility acquired skin wounds were assessed to determine and provide the necessary care and treatment to promote healing and comfort for 1 of 3 residents (R109) in the sample with a skin alteration.<br><br>Findings include:<br><br>R109 developed fluid filled blisters on the bilateral thighs during her stay and did not have interventions developed to address these blisters based on a comprehensive re-assessment of the skin.<br><br>R109 was admitted on 6/1/12, with diagnoses to include congestive heart failure, a blister on top of the right foot, leg weakness and swelling, Deep Vein Thrombosis (DVT), Diabetes Mellitus and was on a palliative care focused plan of care. R109 died on 09/12/12 at the facility.<br><br>A significant change Minimum Data Set (MDS) assessment dated 8/27/12, identified R109 as having cognitive and memory impairments; required extensive assistance from staff with all activities of daily living (ADL) including transfers and used a wheelchair for mobility. The MDS indicated R109 was at risk for developing pressure ulcers and did not have any pressure ulcers, nor any venous or arterial ulcers. The associated Care Area Assessment (CAA) dated 08/27/12, indicated R109's health status had | F 309 | F309<br><br>It is the policy of Johanna Shores that care and services are provided to all residents to ensure the highest level of well being. To ensure continued compliance the following plan has been implemented:<br><br>The care planning policy has been reviewed and remains accurate. All care plans are reviewed and updated in conjunction with the RAI process.<br><br>Resident 109 died on 9/12/12. Residents are assessed for comprehensive skin conditions upon admission, with any significant change in condition and in conjunction with the RAI process.<br><br>Re-education for household staff in regards to Comprehensive Skin Assessment policy to include accurate documentation of all skin conditions was provided during the week of10/15/12 and again 10/29/12.<br><br>Random audits will be completed weekly for 4 weeks and monthly for 2 months to ensure accurate documentation of skin conditions. Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits | 11/13/12 |

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| F 309 | Continued From page 17<br>declined and was receiving hospice services. The CAA indicated R109 was at risk for skin alteration due to impaired physical mobility, non-weight bearing status, needing staff assistance with all ADLs and was repositioned every two hours.<br><br>R109's Braden Scale (a tool used for predicting pressure sore risk) dated 06/01/12, identified R109 as being at mild risk for skin break-down. The correlating Skin Risk Data Collection form indicated R109 had a opened blister on top of the right foot and was at mild risk for skin breakdown. The Wound Assessment Flow Sheet dated 06/01/12, through 06/27/12, indicated the blister on top of right foot was healed.<br><br>The Weekly Bath Skin Assessment form dated 7/20/12, identified R109 had developed a 0.9 centimeter (cm) x 0.5 cm blister on the left front thigh; on 8/24/12, and 8/30/12, the forms identified R109 had "ruptured blisters, some intact" on the front and back of her bilateral thighs.<br><br>R109's temporary care plans dated 8/05/12, and 8/09/12, indicated R109 had a 3.0 cm by 1.5 cm open blister on the right inner knee and blisters on the bilateral thighs, "(One in the front of each thigh)-NP (nurse practitioner) update."<br><br>A form titled "COMPREHENSIVE DATA COLLECTION" significant change dated 8/23/12, identified R109 had small open and fluid filled blisters on the bilateral upper thighs, "(back) & right front thigh." R109's Tissue Tolerance evaluation form (a tool used to determine repositioning needs) dated 08/23/12, indicated, | F 309 | is needed based on compliance results.<br><br>The Clinical coordinator and/or designee are responsible for ongoing compliance.<br><br>Date certain for ongoing compliance is 11/13/2012. | |

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| F 309 | Continued From page 18<br>"Skin intact, redness present and bleachable. Continue to reposition as CP (care plan)." The staff performing the skin evaluation failed to document the multiple blisters on R109's upper thighs. Although staff had documented multiple open/closed blisters on the Comprehensive Data Collection form, the clinical record lacked evidence of any skin re-assessment to develop an individualized care plan to promote healing of these blisters, prevent infections and/or further complications due to the alterations in her skin condition.<br><br>On 10/04/12, at 12:10 p.m. the director of nursing (DON) reviewed R109's clinical record and verified a comprehensive re-assessment was lacking. | F 309 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure repositioning was provided and a care plan developed to address repositioning based on a comprehensive assessment for 1 of 3 residents (R53) in the | F 314 | F314<br><br>It is the policy of Johanna Shores that all residents receive a comprehensive assessment to ensure the prevention of development of pressure sores unless the individual's clinical condition demonstrates they were unavoidable. To ensure continued compliance the following plan has been implemented:<br><br>The care planning policy has been reviewed and remains accurate. All care plans are reviewed and updated in conjunction with the RAI process to include changes in condition. | 11/13/12 |

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| F 314 | Continued From page 19<br>sample reviewed with pressure ulcers.<br><br>Findings include:<br><br>R53 was not provided every two hour repositioning as determined by the comprehensive skin assessment and went for three hours and 35 minutes without repositioning on 10/3/12.<br>R53 had diagnoses to include congestive heart failure, pain in joint, diabetes, chronic kidney disease, and peripheral vascular disease. The annual Minimum Data Set (MDS) dated 5/24/12, indicated R53 was cognitively intact, required extensive assistance with bed mobility and was totally dependent for transfers. The Braden Score (a tool used to predict pressure ulcer development) dated 5/18/12, was 15 indicating mild risk for pressure ulcer development. The undated Comprehensive Skin Data Collection form indicated R53 required every two hour repositioning while in bed and in the wheelchair.<br><br>R53's care plan dated as initiated on 5/25/12, identified a problem with skin integrity related to a diabetic ulcer on the toe, two stage two pressure ulcers on the coccyx, and a problem with mobility in bed and with transfers. The care plan interventions indicated R53 was totally dependent for all transfers, needed extensive assistance with bed mobility, and identified the resident refused to be positioned on her sides. The care plan lacked direction on how frequently R53 required to be repositioned while in bed or in the wheelchair and lacked interventions to address R53's repositioning refusals. | F 314 | A comprehensive re-assessment of resident 53 was completed to identify repositioning needs. Based on assessment results a reposition plan was developed and documented on resident #53's care plan. All residents with current skin conditions have been reviewed and reassessed as needed.<br><br>Re-education on developing a comprehensive care plan and the care planning policy was provided for all Household staff during the week of 10/15/12/and again 10/29/12.<br><br>Random audits will be completed weekly for 4 weeks and monthly for 2 months to ensure accurate development and completion of care plans based on assessment data. Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits is needed based on compliance results.<br><br>The Clinical Administrator and/or designee are responsible for ongoing compliance.<br><br>Date certain for ongoing compliance is 11/13/2012. | |

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| F 314 | Continued From page 20<br>On 10/3/12, at 7:15 a.m. R53 was observed to be seated in a wheelchair in her room and wearing a house dress. At that time, R53 stated she had been up for awhile and needed staff assistance with getting out of bed and with dressing. R53 stated her lower legs would weep and she had wounds on the buttocks. R53 remained seated in the wheelchair in her room until 8:00 a.m. At 8:00 a.m., the resident was wheeled to the dining room. At approximately 9:00 a.m., after leaving the dining area, R53 received her morning medications. R53 went back to her room, remained in the wheelchair and watched television. At 10:27 a.m., R53 put on the call light and notified staff she wanted to attend a scheduled activity. The staff nurse took R53 to the activity in the dining room at 10:35 a.m.. R53 remained at the activity in the dining room and was not repositioned<br>On 10/3/12, at 10:40 a.m. the nursing assistant (NA)-C stated R53 was already up in the wheelchair when he arrived for the morning shift. NA-C stated he assisted R53 with morning cares and confirmed he had not repositioned R53 out of the wheelchair. NA-C stated the resident could tell staff when she needed to use the toilet and confirmed R53 had not been repositioned for at least three (3) hours and 35 minutes.<br>On 10/4/12, at 10:35 a.m. the clinical manager (CM)-C stated R53 could sometimes be non-compliant with repositioning. CM-C verified the current care plan lacked direction to reposition R53 and lacked R53's refusals to be repositioned. CM-C stated the care plan should have been updated and the nursing assistant should have repositioned R53 every two hours. | F 314 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS | F 329 | | |

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| F 329 | Continued From page 21<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include: | F 329 | F329<br><br>It is the policy of Johanna Shores that each resident's drug regimen is free from unnecessary drugs. To ensure continued compliance the following plan has been implemented:<br><br>The Psychotropic medication policy has been reviewed and updated to reflect attempts and documentation of efficacy of non pharmalogical interventions prior to giving prn psychoactive medications.<br><br>The pharmacist consultant reviews all residents monthly. Recommendations for resident 197's drug regimen were noted. Staff update the MAR and care plan to reflect appropriate target behaviors and non pharmalogical interventions for all residents as part of the RAI process.<br><br>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 prn psychoactive medications. | 11/13/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245424 | A. BUILDING _____ B. WING _____ | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PRESBYTERIAN HOMES OF ARDEN HILLS | 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 329 | Continued From page 22<br>R197 was admitted to the facility on 11/15/10, with diagnoses to include dementia without behavioral disturbances, difficulty walking, generalized muscle weakness, and depressive disorder. The annual Minimum Data Set (MDS) assessment dated 9/05/12, identified R197 had cognitive impairment, delusional behaviors and mood symptoms. R197's physician's orders dated 10/1/12, directed to administer lorazepam (Ativan, a short acting benzodiazepine medication used to treat acute anxiety) 0.5 milligrams (mg) half an hour prior to weekly baths for the diagnosis of "anxiety" and one tablet as needed (PRN) every six hours since 11/11/11.<br><br>The Psychotherapeutic Drug Review dated 6/19/12, identified R197 used lorazepam for "anxiety with bath" since 11/11/11. The review indicated the target behaviors of, "Resident occasionally wanders and experiences anxiety - worries about car & kids." The review indicated the behaviors were "unchanged" over the previous quarter. The Psychotherapeutic Drug Review dated 9/4/12, indicated the dosage of lorazepam was unchanged, the target behaviors were listed as, "Sometimes asks about car, moving home. Infrequent episodes of packing belongings." The review indicated the behaviors were "unchanged" over the previous quarter.<br><br>The Medication Administration Record (MAR) dated from 6/24/12, through 10/23/12, indicated R197 was administered PRN Ativan on 6/25/12, and 10/3/12, due to exhibiting the clustered target behaviors of "anxious, wandering, packing, saying she's going home." The approaches listed on the MAR were "redirect" and "activity" however, the documentation whether the facility | F 329 | Random audits will be completed weekly for 4 weeks and monthly for 2 months to ensure accurate documentations of attempts and efficacy of non pharmalogical interventions. Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits is needed based on compliance results.<br><br>The Clinical Administrator and/or designee are responsible for ongoing compliance.<br><br>Date certain for ongoing compliance is 11/13/2012. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 329 | Continued From page 23<br>staff offered these approaches and the results were left blank. The MAR lacked documentation of each target behavior to establish which target behaviors were exhibited, what non-pharmacological approaches were attempted prior to the administration of the Ativan, and the efficacy of the interventions. In addition, the clinical record lacked documentation regarding what types of anxious behaviors were exhibited by R197 prior to or during the bathing activity; what non-pharmacological interventions were attempted and the results of these interventions to reduce or eliminate the use of the weekly Ativan.<br><br>On 10/04/12, at 1:35 p.m. the clinical coordinator (RN)-C reviewed the electronic and paper clinical records and verified R197 had received Ativan weekly and PRN since 11/11/11. RN-C confirmed the clinical record lacked documentation regarding daily monitoring of behaviors, if non-pharmacological interventions were attempted and side-effect monitoring to potentially minimize or eliminate the use of the Ativan. RN-C stated R197 received baths weekly on Wednesdays and the staff should have documented what specific behaviors were exhibited, which non-pharmacological interventions were attempted to address the target behaviors and the efficacy of the interventions.<br><br>The facility policy on Psychotropic medication use dated as revised on 11/20/11, indicated, "Each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drug when used without adequate monitoring, without adequate indications for its use..." The | F 329 | | |

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| F 329 | Continued From page 24<br>policy indicated, "7. Facility staff (such as licensed nurses, certified nursing assistants, activity therapists, social workers, and other staff members) will monitor the resident's medical symptoms, condition, circumstances and environment in order to evaluate the appropriateness of the psychoactive medication being used." The policy further directed facility staff will monitor for side effects of the psychoactive medication, document episodes of behaviors and the "presence or absence of side-effects." The policy lacked direction for non-pharmacological interventions to be attempted prior to use of PRN psychoactive medications. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility's consultant pharmacist failed to ensure the lack of non-pharmacological interventions, monitoring for clinical indications and side effect monitoring of Ativan was identified and reported for 1 of 4 residents (R197). | F 428 | | |

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| F 428 | Continued From page 25<br><br>Findings include:<br><br>R197 received Ativan (a short acting benzodiazepine medication) 0.5 milligrams (mg) half an hour prior to weekly baths; and as needed (PRN) every six hours for anxiety since 11/11/11. The clinical record lacked documentation and development of non-pharmacological interventions, monitoring of clinical indications for use of the medication and monitoring of any side-effects related to the use of Ativan.<br><br>R197 was admitted to the facility on 11/15/10, with diagnoses to include dementia without behavioral disturbances, difficulty walking, generalized muscle weakness, and depressive disorder. The annual Minimum Data Set (MDS) assessment dated 9/05/12, identified R197 had cognitive impairment, delusional behaviors and mood symptoms.<br><br>The Medication Administration Record (MAR) dated from 6/24/12, through 10/23/12, indicated R197 was administered PRN Ativan on 6/25/12, and 10/3/12, due to exhibiting the clustered target behaviors of "anxious, wandering, packing, saying she's going home." The approaches listed on the MAR were "redirect" and "activity" however, the documentation whether the facility staff offered these approaches and the results were left blank. The MAR lacked documentation of each target behavior to establish which target behaviors were exhibited, what non-pharmacological approaches were attempted prior to the administration of the Ativan, and the efficacy of the interventions. In addition, the clinical record lacked documentation regarding | F 428 | F428<br><br>It is the policy of Johanna Shores that each resident's drug regimen is reviewed at least monthly by a licensed pharmacist.<br><br>The Psychotropic medication policy has been reviewed and updated to reflect staff attempts and documentation of efficacy of non pharmalogical interventions prior to giving prn psychoactive medications.<br><br>The pharmacist consultant reviews all residents monthly. The pharmacist consultant has reviewed and provided recommendations for resident 197's drug regimen. Staff update the MAR and care plan to reflect appropriate target behaviors and non pharmalogical interventions for all residents as part of the RAI process.<br><br>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 prn psychoactive medications. Staff were re-educated on role of consultant pharmacist to review resident drug regimen's minimally on a monthly basis and provide recommendations for change as appropriate. | 11/13/12 |

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| PRESBYTERIAN HOMES OF ARDEN HILLS | 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 |

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| F 428 | Continued From page 26<br>what types of anxious behaviors were exhibited by R197 prior to or during the bathing activity; what non-pharmacological interventions were attempted and the results of these interventions to reduce or eliminate the use of the weekly Ativan.<br><br>On 10/04/12, at 1:35 p.m. the clinical coordinator (RN)-C reviewed the electronic and paper clinical records and verified R197 had received Ativan weekly and PRN since 11/11/11. RN-C confirmed the clinical record lacked documentation regarding daily monitoring of behaviors, if non-pharmacological interventions were attempted and side-effect monitoring to potentially minimize or eliminate the use of the Ativan. RN-C stated R197 received baths weekly on Wednesdays and the staff should have documented what specific behaviors were exhibited, which non-pharmacological interventions were attempted to address the target behaviors and the efficacy of the interventions.<br><br>A Consultant Pharmacist Communication to the Physician form dated 9/25/12, identified R197 received "Ativan 0.5 mg weekly before bath." Although the form offered suggested check boxes for the physician to select for a potential dosage reduction. The form did not identify the lack of monitoring for efficacy, non-pharmacological interventions, monitoring for side-effects and the monitoring of target behaviors with the use of lorazepam.<br><br>On 10/12/12, at 2:00 p.m. the consultant pharmacist (CS) stated he was fairly new to the facility. CS stated he needed to "review" R197's | F 428 | Random audits will be completed weekly for 4 weeks and monthly for 2 months to ensure accurate documentations of attempts and efficacy of non pharmalogical interventions. Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits is needed based on compliance results.<br><br>The Clinical Administrator and/or designee are responsible for ongoing compliance.<br><br>Date certain for ongoing compliance is 11/13/2012. | |

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| F 428 | Continued From page 27<br>records to obtain any pertinent information and would "fax it in for review on Monday, 10/15/12." CS stated the nursing staff needed to monitor behaviors, psychotropic medication use and offer non-pharmacological interventions. He further stated he reviewed this data on a monthly basis and if incomplete, then reported the irregularities to the director of nursing and MD.<br><br>The facility's Psychotropic Medication Use policy dated as revised on 11/2011, directed, "Each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drug when used without adequate monitoring, without adequate indications for its use..." The policy further directed, "12. The Pharmacy consultant will review resident medication records on a monthly basis for documentation/justification for the drug use and will recommend dosage reductions or modifications as appropriate."<br><br>On 10/15/12, by 4:30 p.m. no further information was provided. | F 428 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, | F 441 | | |

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| F 441 | Continued From page 28<br>should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure infection control measures of glove changing after handling soiled dressings and handwashing after removing soiled gloves to prevent the potential spread of infections for 2 of 2 residents (R53, R148) observed for cares and a dressing change.<br><br>Findings include:<br><br>R53 was not provided proper infection control | F 441 | F441<br><br>It is the policy of Johanna Shores to ensure Infection Control practices are followed to minimize risk and spread of infection. To ensure continued compliance the following plan has been implemented:<br><br>The facility policy on Infection control has been reviewed and remains accurate. The facility maintains an infection control program to help prevent the development and transmission of disease and infection. The facility policy on pressure ulcers was reviewed and remains accurate.<br><br>Staff were re-educated on proper infection control procedures related to wound treatments for resident 53 and resident 148. Staff were re-educated on proper hand washing techniques, clean maintenance of supplies and equipment and proper disposal of contaminated equipment during the week of 10/15/12 and 10/22/12<br><br>Random audits of proper hand washing, maintenance of infection free equipment, containers and supplies | 11/13/12 |

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| F 441 | Continued From page 29<br>methods during a dressing change. The registered nurse (RN)-C did not change gloves after handling soiled dressings, or wash her hands before applying a clean dressing to an open coccyx wound.<br><br>On 10/3/12, at approximately 1:30 p.m. R53 was observed to be toileted, have a bowel movement and was observed to be transferred to the bed. RN-C stated the wound dressing on the coccyx and left ischeal area was soiled with feces and would need to be changed. Two nursing assistants then laid R53 down in bed. RN-C gathered the necessary supplies to cleanse and dress the wounds. RN-C was observed to don gloves and remove the soiled dressing from the resident's coccyx and left gluteal fold. The wounds were observed to be soiled with a brown colored matter on both wounds. RN-C did not remove the gloves after handling the soiled dressings. RN-C then took approximately five wet wipes out of the package and cleaned the stool soiled rectal area. The soiled wipes where disposed into the trash basket near the bed. With the soiled gloves still on, RN-C applied a white petroleum based cream/paste on the open areas. The areas were re-dressed with a clean tegaderm product and a clean brief was applied. RN-C cleansed the scissors used for cutting the dressing, then picked up other soiled items and disposed of them in a plastic bag. The nurse then removed the soiled gloves, gathered the dressing supplies, the trash bag and left the room. After disposing of the trash, RN-C was observed to wash her hands in the medication room. At the time of the observation, RN-C verified she did not change the soiled gloves, or wash her hands at any time during the dressing | F 441 | will be done weekly for one month and monthly for 2 months. Audits will be reviewed at QA meeting for direction or change if necessary and determine if continuation of audits is needed based on compliance results.<br><br>The Clinical Administrator and/or designee are responsible for ongoing compliance.<br><br>Date certain for the purpose of compliance is 11/13/2012 | |

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| F 441 | Continued From page 30<br>change. RN-C stated she should have changed gloves and washed her hands.<br><br>On 10/3/12, at 8:18 a.m. a nursing assistant (NA) -B was observed to come into R148's room for morning cares. At 8:35 a.m. NA-A came to help due to R148 incontinent of bowel movement (BM). Upon turning R148, a new bleeding wound was observed on the left buttock. NA-B removed gloves after peri care and did not wash hands. Donned another pair of gloves to continue with peri care. NA-A removed gloves and without washing hands went out into the hallway to find the nurse to report the new wound. The registered nurse (RN)-A came into the room and set a container of supplies and dressings on the bedside stand. Without washing hands, RN-A donned a pair of gloves and removed the soiled Allevyn dressing from the coccyx wound and the Allevyn dressing from the right buttock wound. RN-A removed the soiled gloves and without washing hands, donned another pair of gloves to cleanse the three open areas with wound spray, then reached into a open packet of 4x4 clean dressings, and grabbed several to dab the wound areas. RN-A was observed to reach in the 4x4 dressing package again, grab more 4x4's wearing the same soiled gloves and returned the bottle of wound spray to the container. RN-A then applied three Allevyn dressings to the three wounds. RN-A took a marker out of uniform pocket and marked the date on the three dressings and returned the marker to her uniform pocket. RN-A removed gloves and without washing hands, put on a fresh pair of clean gloves to check R148 red swollen penis. RN-A fingered through the dressing bin looking for an ointment to apply to R148's penis with a cotton tip. RN-A removed | F 441 | | |

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| F 441 | Continued From page 31<br>gloves and proceeded to answer the cell phone in the uniform pocket while walking to the sink to wash her hands. RN-A lathered with soap and friction for seven seconds, dried her hands and retrieved the supplies to leave the room. NA-B removed gloves, did not wash hands and put on another pair of fresh gloves to dress R148.<br><br>On 10/3/12, at 12:00 p.m. the director of nursing (DON) verified staff should have washed their hands between glove use and removed the soiled gloves before handling clean supplies and items.<br><br>The facility's Infection Control Hand Hygiene Policy/Procedure dated August 2003 indicated, "Hand hygiene must be performed after touching blood, body fluids, secretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed, and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or the environment." The Ulcer Policy and Procedure dated 10/2/12, directed, "#12. Put on exam glove. Loosen tape and remove dressing. #13. Pull glove over dressing to discard into plastic bag. Wash hands. #14. Put on disposable gloves." | F 441 | | |

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| **PRESBYTERIAN HOMES OF ARDEN HILLS** | **3220 LAKE JOHANNA BOULEVARD**<br>**ARDEN HILLS, MN 55112** |

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| K 000 | INITIAL COMMENTS<br><br>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.<br><br>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.<br><br>The requirement at 42 CFR Subpart 483.70(a) is MET.<br><br>*TEAM COMPOSITION*<br>Tom Linhoff, Life Safety Code Spc. | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245424 | A. BUILDING **02 - 2006 ADDITION**<br>B. WING _____ | **10/02/2012** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PRESBYTERIAN HOMES OF ARDEN HILLS** | **3220 LAKE JOHANNA BOULEVARD**<br>**ARDEN HILLS, MN 55112** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>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.<br><br>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.<br><br>The requirement at 42 CFR Subpart 483.70(a) is MET.<br><br>*TEAM COMPOSITION*<br>Tom Linhoff, Life Safety Code Spc. | K 000 | | |

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

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