

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered July 23, 2021

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

RE: CCN: 245424

Cycle Start Date: June 3, 2021

Dear Administrator:

On July 20, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 21, 2021

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

RE: CCN: 245424

Cycle Start Date: June 3, 2021

Dear Administrator:

On June 3, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

Presbyterian Homes Of Arden Hills June 21, 2021 Page 2

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 3, 2021 (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).

Presbyterian Homes Of Arden Hills June 21, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by December 3, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 06/30/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245424	B. WING			C 03/2021
	PROVIDER OR SUPPLIER TERIAN HOMES OF A	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000		6/3/21, a standard was conducted at your facility.	F 0	00		
	with the requirement Requirements for L	and to be NOT in compliance of 42 CFR 483, Subpart B, ong Term Care Facilities.				
	SUBSTANTIATED: with deficiencies cit	laints were found to be H5424078C (MN00070235), ed at F677 and F686.				
	SUBSTANTIATED:	plaint were found to be H5424077C (MN00062333), uncies were cited due to aken by the facility:				
	as your allegation of Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will cion of compliance.				
F 077	onsite revisit of you validate that substa regulations has been		F.0	77		7/40/04
F 677 SS=D		for Dependent Residents 2)	F 6			7/16/21
	out activities of daily services to maintain personal and oral h	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced				
	Based on observat	ion, interview, and document		This Plan of Correction and the		040. 2.22
ABORATOR\	LUBECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE

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

(X6) DATE

Electronically Signed

06/29/2021

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:			(X3) DATE SURVEY COMPLETED	
		245424	B. WING		06/0) 3/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 55/5	
PRESBY	TERIAN HOMES OF	ARDEN HILLS		3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	Continued From pa	age 1	F 67	7		
	incontinence care, for 1 of 3 residents incontinent of bowe	ailed to implement timely as directed by the care plan, (R3) who was always and bladder.		responses to each F-Tag are sub maintain certification in the Medic Medicaid programs and constitute credible allegation of compliance written responses do not constitu	are and a a The	
	Findings include:	-11-0/0/04		admission of noncompliance or agreement with any findings state		
		ated 6/3/21, indicated entia without behavioral leart failure.		the F-Tags. The facility reserves i to dispute all findings and deficier any appropriate forum, including i independent dispute resolution, o	ncies in n an	
	4/21/21, indicated limpairment, and re	mum Data Set (MDS) dated R1 had severe cognitive quired extensive assistance s always incontinent of bowl		appealable remedies are subsequimposed, by timely appeal to the Departmental Appeals Board.		
	and bladder.			R3 was provided assistance with incontinence care upon identification.	ion. R3	
	(CAA) dated 1/26/2 incontinent of bowl indicated R3 requirements	der care area assessment 21, indicated R1 was and bladder. The CAA further ed staff assistance due to bility to stand or walk.		has had a Bowel, Bladder and Sk assessment completed on 4/23/2 ensure that she has been comprehensively assessed and the plan of care and care sheets matindividualized needs identified on	021 to nat her ch the	
	functional bladder/l required assistance change their incom	ed 5/5/21, indicated R3 had bowel incontinence and e of two staff to check and cinence product every three		assessment. NAR caring for R3 v provided education and coaching to not following plan of care and p process for refusal of care. A full	vas related proper house	
	indicated if R3 refu staff were to reapp			audit is being completed for all curesidents, including review of care care sheet, and assessments to engoing compliance and safety re	e plan, ensure	
		gress notes dated 4/1/21, ked indication documentation		ADLs for dependent residents. The facility has reviewed the police Toileting Residents and it remains appropriate. All nursing staff are	receiving	
	2:01 p.m. At 10:24	a.m. a continuous onducted from 10:24 a.m. to a.m. R3 was seated in a a television in their room with		education on the process to ensu plan of care is being followed usin care sheets and shift report. In ac staff will be educated on refusals	re the ng the ldition,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		245424	B. WING			C 03/2021
	PROVIDER OR SUPPLIER	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 677	(NA)-A entered R3' was ready for lunch dining room without incontinence. At 12 wheelchair and was At 12:41 p.m. R3 re wheelchair in dining staff and residents. 12:55 p.m. R3 rem in dining room and At 12:58 p.m. R3 wand continued to with the wheelchair. R3 2:01p.m., after survincontinence cares offered to help R3 incontinence cares be changed and watelevision show. R3 incontinent cares for At 3:27 p.m., R3 was lifted in R3's clothing and li with urine and stoomedness on R3's but (cm) by four cm and blanchable. R3 was performed. Prior to reapproach R37 were with the stated R3 had been 8:00 a.m. NA-A stated R3 had been 8:00 a.m. NA-A stated R3 refused. NA-A care at about 10:45	2:05 a.m., nursing assistant s room and asked R3 if she n. NA-A then brought R3 to the t offering to check for t:12 p.m. R3 remained in her seating lunch in dining room. It is eating lunch in the groom and was visiting with Toileting was not offered. At ained seated in the wheelchair was talking with the Chaplain. It is wheeled back to her room atch television while seated in was not offered toileting. At veyor inquiry regarding, NA-A entered R3's room and return to bed and provide. R3 stated she did not want to as concentrating on the shad not been offered or three hours and 37 minutes. It is as reapproached by NA-B and LPN-B assisted R3 back to not bed with a hoyer lift and for sling was noted to be soiled so the lift can be did not perineal cares did verified the red area was so changed and perineal cares 3:27 p.m. no attempts to	F 67	reapproach in regard to activities living (ADLs). The facility will complete random 10% of residents using their car to ensure their services provided the care sheet/care plan weekly ongoing compliance with cares a services. The results of these a be reviewed by the Quality Assuteam who will determine the free ongoing audits. The Clinical Administrator or deside responsible for ongoing compliance is Friday 2021.	n audits of e sheets d match to ensure and audits will trance quency of signee will pliance;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED	
		245424	B. WING _			C / 03/2021	
	PROVIDER OR SUPPLIER	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP C 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 677	was sometimes constated when R3 refibe notified and R3 further stated upon lunchtime and R3 was every three. Contraupon continuous of R3 were observed. When interviewed a stated R3 needed thours and required incontinence cares unaware R3 had rewas not aware how NA-A reported the LPN-A stated when documented refusal information was also when interviewed a stated R3 was incontinence cares. Note that the care was not aware to was not aware how NA-A reported the LPN-A stated when documented refusal information was also when interviewed a stated R3 was incontinented refusal of care need trying. NA-B stated when R3 refused. Note that the election is the election of two the registered nurse (Figure 1) when interviewed a regist	ated R3 refused cares and infused and combatitive. NA-A used cares, LPN-A needed to should be reapproached. NA-A return from break, it was was brought to the dining room. as to have incontinent cares ary to the above statement, oservation, no attempts to toilet	F 67				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245424	B. WING			C 03/2021
	PROVIDER OR SUPPLIER TERIAN HOMES OF A	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	1 00/	03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 686 SS=D	care was still refuse RN-A stated the nur resident. RN-A state to document in the care. When interviewed of stated R3 needed in the performed every stated when R3 refused reapproach a reside completed. LPN-B is not successful a profuse of the complete o	happen within the hour and if ed, the nurse must be notified. It is should also approach the ed both nurses and NA's need EMR when a resident refused on 6/2/21, at 4:00 p.m. LPN-B incontinence care and it was to a two to three hours. LPN-B used care, staff needed to ent until the cares were stated if reapproaching was ogress note was needed. In 6/3/21, at 12:35 p.m., (DON) stated the expectation of a resident's care plan. The ident refused care, the reassessed, or reapproached utes. Toileting Residents dated the level of dependence and resident's toileting will be re plan. and nursing will nce each shift. Prevent/Heal Pressure Ulcer 1)(i)(ii)	F6	77		7/16/21
	Based on the comp resident, the facility (i) A resident receiv professional standa pressure ulcers and	rehensive assessment of a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245424	B. WING		C 06/03/2021	
	PROVIDER OR SUPPLIER	ARDEN HILLS	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	30,00,2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE COMPLÉTION	1
F 686	(ii) A resident with necessary treatme with professional spromote healing, pnew ulcers from de This REQUIREME by: Based on observareview the facility fulcer interventions 1 of 3 residents (Rulcers. Findings include: R3's Face Sheet diagnoses of demedisturbances and health of the diagnoses of demediate diagnoses diagnoses of de	they were unavoidable; and bressure ulcers receives int and services, consistent tandards of practice, to revent infection and prevent eveloping. NT is not met as evidenced ition, interview, and document ailed to implement pressure of turning and repositioning for identified at risk for pressure of turning and repositioning for identified at risk for pressure in the identified at risk for in the identified at risk for it is in the identified at risk for it is indicated R3 was	F 686	R3 was provided assistance with immediate care upon identification. has had a Bowel, Bladder and Skir assessment completed on 4/23/20 ensure that she has been comprehensively assessed and that plan of care and care sheets match individualized needs identified on the assessment. NAR caring for R3 was provided education and coaching not not following plan of care, proper process for refusal of care and potential po	a Risk 21 to at her in the inis as elated rential elated its audit is dents, sheet, ag ressure in ag et the gitten, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245424	B. WING			06/0) 03/ 2021
NAME OF I	PROVIDER OR SUPPLIER		I		TREET ADDRESS, CITY, STATE, ZIP CODE	,	
PRESBY	TERIAN HOMES OF	ARDEN HILLS		_	220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	R3's care plan date able to ambulate, r for repositioning, a pressure injuries. R3 was to be repositioned as needed. If R3's return and reapproximate R3's progress note through 6/1/21, lactorepositioning. On 6/2/21, a continuous c	ed 5/5/21, indicated R3 was not required assistance of two staff nd was at risk for developing The care plan further indicated sitioned every three hours and refused cares, staff were to	F6	886	The facility will complete random at 10% of residents weekly to ensure ongoing compliance with provision to prevent pressure injury developed directed by the care sheet/care play addition, the facility will audit 10% or residents with skin issues to ensure ongoing provision of care as direct their individualized plan of care. The results of these audits will be reviet the Quality Assurance team who will determine the frequency of ongoing audits. The Clinical Administrator or design be responsible for ongoing compliated date of compliance is Tuesday, 16, 2021.	of care nent as n. In of all e ed by e wed by ill g	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED	
		245424	B. WING _			C / 03/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	Continued From pa	-	F 68	86			
	buttocks was varyi extended down to measured the redrinine centimeters (ored area was bland made no attempts repositioning. When interviewed stated R3 had bee 8:00 a.m. NA-A state to bed and be char R3 refused. NA-A care at about 10:44 and R3 was not refuer break. NA-As was sometimes constated when R3 refuend when R3 refuend and R3 further stated upor lunchtime and R3 further stated upor lunchtime and R3 with the stated when R3 refuend R3 were 2:01 p.m. When interviewed stated R3 had to be hours. LPN-A state refused repositioni aware how long R3	f urine and stool. R3's ing shades of red which the top of their legs. LPN-B less on R3's buttocks to be em) by four cm and verified the chable. Prior to 3:27 p.m. staff to reapproach R37, to offer on 6/2/21, at 1:54 p.m. NA-A in their wheelchair since about sted R3 was offered to get backinged around 10:45 a.m., but confirmed when R3 refused approached as it was time for tated R3 refused cares and infused and combative. NA-A fused cares, LPN-A needed to should be reapproached. NA-A return from break, it was was brought to the dining room. The state of the above statement, be been above statement, be repositioned every three and he was not notified R3 had ing. LPN-A stated he was not 8 was in their wheelchair until in just now. LPN-A stated when					
	R3 refused care, s few minutes. LPN- refuse, the charge LPN-A also stated	A stated if R3 continued to nurse needed to be notified. if a resident refused cares this nted in a progress notes and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245424	B. WING				C 03/2021
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	stated R3 was res stated if R3 refuse NA-B stated, at tim different person. No be notified when FR3 was not able to wheelchair and rec NA-B stated R3's indocumented on the medical record (EI When interviewed registered nurse (If for NAs' to follow the RN-A stated when NA staff needed to reapproach should care was still refuse RN-A stated the nuresident. RN-A stated to document in the care. When interviewed stated R3 needed three hours. LPN-I staff needed to reacares were complereapproaching was note was needed. When interviewed director of nursing expected to follow DON stated if a resident and the care was needed.	on 6/2/21, at 2:21 p.m. NA-B istive to cares, at times. NA-B d, staff needed to reapproach. nes, R3 was agreeable with a IA-B stated a nurse needed to refused cares. NA-B stated o reposition herself in a quired assistance of two staff. refusal of care needed to be e task sheet in the electronic	F	686			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245424	B. WING			C 03/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		03/2021
PRESBY	TERIAN HOMES OF A	ARDEN HILLS		3220 LAKE JOHANNA BOULEVARD		
				ARDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		IOULD BE	(X5) COMPLETION DATE
F 686	and follow-up with a document refusals	ge 9 a nurse. The DON stated NAs' in their task sheets and nurses care in a progress notes.	F 6	86		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 21, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: 7RTJ11

Dear Administrator:

The above facility was surveyed on June 2, 2021 through June 3, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

Presbyterian Homes Of Arden Hills June 21, 2021 Page 2

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Jamie Perell, Unit Supervisor Metro A District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: jamie.perell@state.mn.us

Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

· Pri6

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

(X6) DATE

If continuation sheet 1 of 12

PRINTED: 06/30/2021 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00975 06/03/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD PRESBYTERIAN HOMES OF ARDEN HILLS ARDEN HILLS, MN 55112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was

INITIAL COMMENTS:

corrected.

On 6/2/21, through 6/3/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

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

Minnesota Department of Health

STATE FORM

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

Electronically Signed

06/29/21

7RTJ11

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00975	B. WING			C 03/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
		3220 ΔΙ		BOULEVARD		
PRESBY	TERIAN HOMES OF A	ARDEN HILLS ARDEN I	HLLS, MN 55	5112		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	ECTION	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED:	laint was found to be H5424078C (MN70253) with ssued at 0840, 0905 and				
	SUBSTANTIATED:	laint was found to be H5424077C (MN62333), ng orders were issued.				
	the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far-le	ent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix				
	listed in the "Summ column and replace the correction order the findings which a statute after the sta	tute/rule out of compliance is ary Statement of Deficiencies' es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met				
	are the Suggested Time Period for Cor	ollowing the surveyor's findings Method of Correction and rrection. participate in the electronic				
	receipt of State lice the Minnesota Depa Informational Bullet	nsure orders consistent with artment of Health in 14-01, available at				
	n/infobulletins/ib14_ orders are delineate	state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota				
	you electronically. Is necessary for Sta	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box				
	available for text. You electronic State lice heading completion	ou must then indicate in the ensure process, under the date, the date your orders will be electronically submitting to				

Minnesota Department of Health

STATE FORM 6899 7RTJ11 If continuation sheet 2 of 12

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7.1.12 . 2.11.	0. 0020	.52.11.11.07.11.01.13.11.1	A. BUILDING:			
		00975	B. WING		06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	ARDEN HILLS	E JOHANNA IILLS, MN 55	N BOULEVARD 5112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	 age 2	2 000			
	is enrolled in ePOC	artment of Health. The facility and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE.				
2 840	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 B Adequate and re; Clean skin	2 840			7/16/21
		or determining adequate and criteria for determining er care include:				
	odors. A bathing p resident's plan of c condition requires t must be given a co other day and more incontinent residen every two hours, ar	and freedom from offensive lan must be part of each are. A resident whose that the resident remain in bed implete bath at least every e often as indicated. An it must be checked at least and must receive perineal care code of incontinence.				
	Notwithstanding Mi 4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a f appointed conserva agent of a resident	1. Incontinent residents. Innesota Rules, part Intinent resident must be Ito a specific time interval Interval ent's care plan. The resident's In must authorize in writing any It two hours unless the resident, I amily member or legally I ator, guardian, or health care I who is not competent, agrees I part of the state of the sta				

Minnesota Department of Health

Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00975	B. WING		06/0) 3/2021	
					1 00/0	3/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
PRESBY	TERIAN HOMES OF A	ARDEN HILLS	ILLS, MN 5	A BOULEVARD 5112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 840	Continued From pa	ge 3	2 840				
		erval, and this waiver is resident's care plan.]					
	promptly each time Perineal care include the perineal area. It to keep the bed dry comfort. Special at skin to prevent irritat types of protectors completely covered contact with the res	hing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's tention must be given to the tion. Rubber, plastic, or other must be kept clean, be, and not come in direct ident. Soiled linen and moved immediately from event odors.					
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement timely incontinence care, as directed by the care plan, for 1 of 3 residents (R3) who was always incontinent of bowel and bladder.			Corrected			
	Findings include:						
	R3's Face Sheet dated 6/3/21, indicated diagnoses of dementia without behavioral disturbances and heart failure.						
	4/21/21, indicated F impairment, and red	num Data Set (MDS) dated R1 had severe cognitive quired extensive assistance s always incontinent of bowl					
		der care area assessment 1, indicated R1 was					

Minnesota Department of Health

STATE FORM 6899 7RTJ11 If continuation sheet 4 of 12

Minnesota Department of Health

AND DUAN OF CODDECTION INDED.					(3) DATE SURVEY COMPLETED	
			7. Boilding.		С	
		00975	B. WING			3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRESRY	TERIAN HOMES OF	ARDEN HILLS 3220 LAK	E JOHANNA	BOULEVARD		
	TERMAN TIOMES OF A	ARDEN H	ILLS, MN 55	5112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 840	Continued From pa	ge 4	2 840			
	incontinent of bowl and bladder. The CAA further indicated R3 required staff assistance due to weakness and inability to stand or walk.					
	R3's care plan dated 5/5/21, indicated R3 had functional bladder/bowel incontinence and required assistance of two staff to check and change their incontinence product every three hours and as needed. R3's care plan further indicated if R3 refused to be checked or changed, staff were to reapproach R3.					
	Review of R3's progress notes dated 4/1/21, through 6/3/21, lacked indication documentation R3 refused cares.					
	On 6/2/21, at 10:24 a.m. a continuous observation was conducted from 10:24 a.m. to 2:01 p.m. At 10:24 a.m. R3 was seated in a wheelchair watching television in their room with the door open. At 12:05 a.m., nursing assistant (NA)-A entered R3's room and asked R3 if she was ready for lunch. NA-A then brought R3 to the dining room without offering to check for incontinence. At 12:12 p.m. R3 remained in her wheelchair and was eating lunch in dining room. At 12:41 p.m. R3 remained seated in the					
	staff and residents. 12:55 p.m. R3 remain dining room and At 12:58 p.m. R3 wand continued to withe wheelchair. R3 2:01p.m., after survincontinence cares offered to help R3 rincontinence cares be changed and was	g room and was visiting with Toileting was not offered. At ained seated in the wheelchair was talking with the Chaplain. as wheeled back to her room atch television while seated in was not offered toileting. At reyor inquiry regarding, NA-A entered R3's room and return to bed and provide. R3 stated she did not want to as concentrating on the				

Minnesota Department of Health

STATE FORM 6899 7RTJ11 If continuation sheet 5 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED		
00975		B. WING			C 03/2021		
		00973				00/0	03/2021
NAME OF PROVIDER	OR SUPPLIER				STATE, ZIP CODE		
PRESBYTERIAN	HOMES OF	ARDEN HILLS		E JOHANNA ILLS, MN 55	BOULEVARD 5112		
PREFIX (EA	CH DEFICIENC	TEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
incontine At 3:27 LPN-B. bed. R3 R3's clowith uril redness (cm) by blanchar perform reapproximate at the state of R3 refures at the state of R4 refures at t	p.m., R3 way NA-B and Lawas lifted in thing and soon R3's but four cm and lifted. Prior to each R37 was not read in NA-A stand be charased. NA-A stand be charased. NA-A stand be charased. NA-A stand lifted in R3 refited and R3 was not read in the each continuous of the contract of the contract in the	or three hours an as reapproached LPN-B assisted Finto bed with a hoft sling was noted I. LPN-B measurattocks to be nined verified the red is changed and part of the series of the seri	by NA-B and R3 back to over lift and d to be soiled ed the excentimeters area was perineal cares empts to 4 p.m. NA-A air since about ed to get back 5 a.m., but R3 refused was time for cares and patitive. NA-A N-A needed to roached. NA-A k, it was e dining room. tinent cares statement, tempts to toilet p.m., LPN-A rery three per was N-A stated he her chair until or minutes ago. es, staff potes and the				

Minnesota Department of Health

STATE FORM 6899 7RTJ11 If continuation sheet 6 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
	00975		B. WING			C 03/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	,	
PRESBY	TERIAN HOMES OF A	ARDEN HILLS	KE JOHANNA HILLS, MN 59	A BOULEVARD 5112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 6	2 840			
	stated R3 was incomattempting cares. No cares, staff needed trying. NA-B stated when R3 refused. No reposition herself in assistance of two to refusal of care need task sheet in the electric (EMR). When interviewed of registered nurse (R for NAs' to follow the RN-A stated when a NA staff needed to	on 6/2/21, at 2:21 p.m., NA-B ntinent and could resist when IA-B stated when R3 refused to reapproach and keep a nurse should be notified NA-B stated R3 was not able to her wheelchair and required o move. NA-B stated R3's ded to be documented on a ectronic medical record on 6/2/21, at 3:21 p.m. iN)-A stated it was expected the care plan for the residents. a resident refused care, the reapproach. RN-A stated the				
	care was still refuse RN-A stated the nur resident. RN-A state	happen within the hour and if ed, the nurse must be notified. rse should also approach the ed both nurses and NA's need EMR when a resident refused				
	stated R3 needed in be performed every stated when R3 reformed reapproach a residence completed. LPN-B states	on 6/2/21, at 4:00 p.m. LPN-B incontinence care and it was to two to three hours. LPN-B used care, staff needed to ent until the cares were stated if reapproaching was ogress note was needed.				
	director of nursing (was for staff to follo DON stated if a res	on 6/3/21, at 12:35 p.m., (DON) stated the expectation ow a resident's care plan. The ident refused care, the reassessed, or reapproached utes.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		00975	B. WING) 3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	ARDEN HILLS	E JOHANNA ILLS, MN 5	A BOULEVARD 5112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	12/2014, indicated time frame's of the identified on the camonitor for compliant SUGGESTED MET Director of Nursing develop, review, an procedures to ensutoileting and process if a resident refuses could educate all st procedures. The Dedevelop monitoring compliance.	Toileting Residents dated the level of dependence and resident's toileting will be re plan. and nursing will	2 840			
2 905	Subp. 4. Positioning positioned in good of residents unable must be changed a including periods of been put to bed for has documented the hours during this tire the physician has of this MN Requirements. This MN Requirements by: Based on observations and the physician has of the	g. Residents must be body alignment. The position to change their own position to change their own position to least every two hours, if time after the resident has the night, unless the physician at repositioning every two me period is unnecessary or redered a different interval. The provided has a seridenced and interview, and document alled to implement pressure of turning and repositioning for all interview and denoting the pressure of turning and repositioning for all interviews.	2 905	Corrected		7/16/21

Minnesota Department of Health

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00975		B. WING		06/0	3/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 8	2 905			
	ulcers.					
	Findings include:					
		ated 6/3/21, indicated ntia without behavioral eart failure.				
	4/21/21, indicated F impairment, require staff for bed mobility	num Data Set (MDS) dated R1 had a severe cognitive and extensive assistance of two y, and was totally dependent sfers. R3 was noted to have a injury.				
	(CAA) dated 1/26/2 pressure ulcers due bladder. R3 require	y Care Area Assessment 1, indicated R3 was at risk for to incontinence of bowl and d assistance of two staff for us not able to stand or walk.				
	dated 4/23/21, indic for skin breakdown.	and Skin Risk Summary cated R3 was at moderate risk. R1 was to be repositioned uring the day and every four ght.				
	able to ambulate, refor repositioning, ar pressure injuries. T R3 was to be repos	d 5/5/21, indicated R3 was not equired assistance of two staff nd was at risk for developing he care plan further indicated itioned every three hours and refused cares, staff were to each R3.				
		s reviewed from 4/1/21, ked indication R3 refused				
	On 6/2/21, a continu	uous observation from at				

Minnesota Department of Health

STATE FORM 6899 7RTJ11 If continuation sheet 9 of 12

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		A. BUILDING.		C	,		
	00975		B. WING			3/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PRESBY	TERIAN HOMES OF A	ARDEN HILLS		BOULEVARD			
240.15	CLIMMA DV CTA		ILLS, MN 55			0/5	
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TION SHOULD BE COMPL THE APPROPRIATE DATI		
2 905	Continued From pa	ge 9	2 905				
2 900	10:24 a.m. to 2:01 pobserved sitting in a television in their roassistant (NA)-A en R3 if she was ready R3 to the dining roor repositioning at this seated in her wheel dining room. At 12: in the wheelchair in staff and other resist repositioning. At 12 in her wheelchair in a Chaplin. At 12:58 their room and was this time. R3 continus seated in the wheel entered R3's room and to change R3's she did not want to she was concentrat was not offered rep 37 minutes. At 3:27 by NA-B and LPN-ER3 back to bed. R3 hoyer lift and R3's of to be incontinent of buttocks was varying extended down to the measured the rednormade no attempts to repositioning. When interviewed of stated R3 had been 8:00 a.m. NA-A staft to bed and be changed.	o.m. At 10:24 a.m. R3 was a wheelchair watching om. At 12:05 a.m. nursing tered R3's room and asked of for lunch. NA-A then wheeled om and was not offered of time. At 12:12 p.m. R3 was lchair eating lunch in the 41 p.m., R3 remained seated dining room and visited with dent. R3 was not offered :55 p.m. R3 remained seated the dining room and spoke to p.m. R3 was wheeled back to not offered repositioning at nued to watch television while chair. At 2:01p.m. NA-A and asked R3 to return to bed incontinent pad. R3 told NA-A go to bed, or be changed, and ing on a television show. R3 ositioning for three hours and p.m. R3 was reapproached a. NA-B and LPN-B assisted was lifted into bed with a clothing and lift sling was noted urine and stool. R3's ag shades of red which he top of their legs. LPN-B less on R3's buttocks to be m) by four cm and verified the hable. Prior to 3:27 p.m. staff to reapproach R37, to offer	2 903				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED	
00975		B. WING			C 03/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF A	ARDEN HILLS	E JOHANNA IILLS, MN 55	A BOULEVARD 5112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 905	care at about 10:45 and R3 was not real her break. NA-A stawas sometimes constated when R3 refibe notified and R3 starther stated upon lunchtime and R3 withree hours. Contraupon continuous obreposition R3 were 2:01 p.m. When interviewed a stated R3 had to be hours. LPN-A stated refused repositionin aware how long R3 NA-A informed him R3 refused care, stated refused care, stated was to be document communicated to the When interviewed a stated R3 was resisted if R3 refused NA-B stated, at time different person. NA be notified when R3 was not able to wheelchair and required not the medical record (EM)	a.m., LPN-A was not notified approached as it was time for ated R3 refused cares and afused and combative. NA-A used cares, LPN-A needed to should be reapproached. NA-A return from break, it was was brought to the dining room. as to be repositioned every ry to the above statement, as ervation, no attempts to observed from 10:24 a.m until on 6/2/21 at 2:07 p.m., LPN-A repositioned every three do he was not notified R3 had ag. LPN-A stated he was not was in their wheelchair until just now. LPN-A stated when aff needed reapproach after a A stated if R3 continued to nurse needed to be notified. If a resident refused cares this ated in a progress notes and the next shift. On 6/2/21, at 2:21 p.m. NA-B attive to cares, at times. NA-B attive to cares, at times. NA-B attive to cares, at times. NA-B attive to cares. NA-B stated a nurse needed to B refused cares. NA-B stated reposition herself in a uired assistance of two staff. Efusal of care needed to be task sheet in the electronic	2 905			

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
71112 1 27111		BERTH TO THOU HOMBETT.	A. BUILDING:				
	00975		B. WING		C 06/03/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PRESBY	TERIAN HOMES OF A	ARDEN HILLS	E JOHANNA ILLS, MN 55	BOULEVARD 5112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
	for NAs' to follow the RN-A stated when a NA staff needed to reapproach should care was still refuse RN-A stated the nuresident. RN-A stated to document in the care. When interviewed a stated R3 needed to three hours. LPN-B staff needed to reapproaching was note was needed. When interviewed a cares were comple reapproaching was note was needed. When interviewed a director of nursing a expected to follow to DON stated if a respected to follow to DON stated if a respected to follow to DON stated if a respected to follow and follow-up with a document refusals document refused a suggestion of nursing a review and revise pto positioning. The staff and conduct a being followed.	inge 11 in (N)-A stated it was expected the care plan for the residents. It resident refused care, the reapproach. RN-A stated the happen within the hour and if the ed, the nurse must be notified. The resident refused approach the red both nurses and NA's need EMR when a resident refused and 6/2/21, at 4:00 p.m. LPN-B to be repositioned every two to the resident until the red. LPN-B stated if not successful a progress and 6/3/21, at 12:35 p.m. (DON) stated staff were the resident's care plan. The ident refused care, staff must toach within 30 to 60 minutes a nurse. The DON stated NAs' in their task sheets and nurses care in a progress notes. THOD OF CORRECTION: The (DON), or designee, could toolicies and procedures related DON, or designee, could train udits to ensure care plans are	2 905				

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