DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 23, 2026

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

RE: CCN: 245424
Cycle Start Date: June 29, 2026

Dear Administrator:

On July 21, 2026, 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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July 23, 2026

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

Re: Reinspection Results
Event ID: 25C022-H2

Dear Administrator:

On July 21, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 29, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 2, 2026

Administrator
Presbyterian Homes Of Arden Hills
3220 LAKE JOHANNA BOULEVARD
ARDEN HILLS, MN 55112

RE: CCN:245424
Cycle Start Date: June 29, 2026

Dear Administrator:

On June 29, 2026, a survey was completed at your facility by the Minnesota Department of Health 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:

- 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 29, 2026 (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).

In addition, if substantial compliance with the regulations is not verified by December 29, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

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

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July 2, 2026

Administrator
Presbyterian Homes Of Arden Hills
3220 LAKE JOHANNA BOULEVARD
ARDEN HILLS, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: 25C022-H1

Dear Administrator:

The above facility survey was completed on June 29, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Arden Hills	**3220 LAKE JOHANNA BOULEVARD , ARDEN HILLS, Minnesota, 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
F0000	INITIAL COMMENTS On 6/29/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed without deficiency: H54242921C (3042786). As a result of an incident finding, a deficiency was cited at F656. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		07/03/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and	F0656	R1's care plan was immediately reviewed and revised. The outdated intervention was removed. The Director of Nursing or designee completed an audit of all residents with a transfer assessment completed within the previous 90 days to ensure the care plan accurately reflects the current transfer method and is consistent with the current transfer assessment and CNA care guide. Licensed nurses and IDT members responsible for care plan updates were re-educated on the facility's Care Plan Policy, including the requirement to update care plans after any change and remove outdated interventions. Weekly audits will be completed on 15% of all residents for four (4) weeks, then monthly for two (2)	07/16/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0656 SS = D	Continued from page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to review and revise a care plan for 1 of 3 residents (R1) whose care plan was reviewed for revisions. Findings include: R1’s annual Minimum Data Set (MDS) dated 5/8/26, indicated R1 was moderately cognitively impaired, dependent on staff for transfers from surface to surface, and had diagnoses included dementia. R1’s care plan dated 1/23/26, indicated R1’s family member (FM)-A gave verbal permission for R1 to continue to use the stand aid lift as long as the resident was able to do so and understood the risk of bruising and skin tears R1 may receive.	F0656	Continued from page 1 months, to verify the transfer assessment, care plan, and CNA care guide are consistent and that outdated transfer interventions have been removed. The results of these audits will be reviewed by the facility Quality Assurance and Performance Improvement (QAPI) committee for ongoing compliance. The Clinical Administrator and or designee is responsible for ongoing compliance. Date certain for compliance is 7/16/2026	07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/29/2026

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F0656 SS = D	Continued from page 2 R1's Resident Transfer Assessment dated 5/1/26, indicated R1 was full weight bearing, was able to stand for 8 (eight) seconds safely while holding onto an assistive device, and was cooperative during transfers. The recommended mechanism for transfers from surface to surface was a two-person transfer with the stand assist lift. R1's progress note dated 6/11/26 at 10:40 a.m., indicated R1 may no longer be appropriate for the stand aid lift, and a Resident Transfer Assessment would be completed. R1's Resident Transfer Assessment dated 6/11/26, indicated R1 was partial weight bearing, could not stand for 8 seconds safely while holding onto an assistive device, and was cooperative during transfers. The recommended mechanism for transfers from surface to surface was a two-person transfer will a full body lift. R1's care plan dated 6/11/26, indicated R1 required assistance of two staff with a full lift and medium sling. The care plan intervention to utilize the stand assist lift remained on the care plan without an end date. R1's progress notes dated 6/22/26 at 4:50 p.m., indicated R1 was transferred to the emergency department on 6/12/26 for a skin tear, and was changed from a stand assist lift to a full lift on 6/11/26. During an interview on 6/29/26 at 11:05 a.m., the FM-A stated that after R1 was injured using the stand assist lift on 6/12/26, the staff started to use a full lift. During an interview on 6/29/26 at 1:03 p.m., the registered nurse (RN)-A stated R1's ability to transfer using a stand assist lift was reassessed on 6/11/26 because staff were concerned about her ability to transfer safely. R1 was assessed and subsequently required a full body lift. The change was indicated on R1's care sheet utilized by the nursing assistants (NA) and on R1's care plan. The RN-A acknowledged when R1's care plan was updated to indicate use of the full body lift, the	F0656		07/16/2026

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F0656 SS = D	Continued from page 3 intervention to utilize the stand assist lift was not removed and an end date was not added. During an interview on 6/29/26 at 2:27 p.m., the licensed practical nurse (LPN)-A stated R1's transfer status was assessed on 6/11/26 and was changed from a stand aid lift to a full body lift because she was no longer able to stand for 8 seconds, had bruising on her lower extremities because she could not bear weight and had to lean heavily on the lift. The LPN-A stated he added the full body lift to R1's care plan and acknowledged he did not remove the stand aid lift from R1's care plan or add an end date, which could be confusing for staff. During an interview on 6/29/26 at 4:03 p.m., the nursing assistant (NA)-A stated if the correct lift was not utilized, accidents during transfers of residents could happen. During an interview on 6/29/26 at 4:32 p.m., the director of nursing (DON) stated any discrepancy in the care plan could be a problem for a resident and acknowledged the care plan was updated with new information for R1's transfers, but the information about the previous transfer status had not been removed and an end date was not added. The Care Plan Policy and Procedure dated 11/22, indicated changes to the care plan would be made as necessary resulting from significant changes in condition or needs and should be current at all times.	F0656		07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/29/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed with no deficiency issued: H54242921C (3042786).	20000		07/03/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/29/2026**

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20000	Continued from page 1 As a result of an incidental finding a licensing order was issued at 0565. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		07/03/2026
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as	20565	R1's care plan was immediately reviewed and revised. The outdated intervention was removed. The Director of Nursing or designee completed an audit of all residents with a transfer assessment completed within the previous 90 days to ensure the care plan accurately reflects the current transfer method and is consistent with the current transfer	07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/29/2026**

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Presbyterian Homes Of Arden Hills	**3220 LAKE JOHANNA BOULEVARD , ARDEN HILLS, Minnesota, 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
20565	Continued from page 2 evidenced by: Based on interview and document review the facility failed to review and revise a care plan for 1 of 3 residents (R1) whose care plan was reviewed for revisions. Findings include: R1's annual Minimum Data Set (MDS) dated 5/8/26, indicated R1 was moderately cognitively impaired, dependent on staff for transfers from surface to surface, and had diagnoses included dementia. R1's care plan dated 1/23/26, indicated R1's family member (FM)-A gave verbal permission for R1 to continue to use the stand aid lift as long as the resident was able to do so and understood the risk of bruising and skin tears R1 may receive. R1's Resident Transfer Assessment dated 5/1/26, indicated R1 was full weight bearing, was able to stand for 8 (eight) seconds safely while holding onto an assistive device, and was cooperative during transfers. The recommended mechanism for transfers from surface to surface was a two-person transfer with the stand assist lift. R1's progress note dated 6/11/26 at 10:40 a.m., indicated R1 may no longer be appropriate for the stand aid lift, and a Resident Transfer Assessment would be completed. R1's Resident Transfer Assessment dated 6/11/26, indicated R1 was partial weight bearing, could not stand for 8 seconds safely while holding onto an assistive device, and was cooperative during transfers. The recommended mechanism for transfers from surface to surface was a two-person transfer will a full body lift. R1's care plan dated 6/11/26, indicated R1 required assistance of two staff with a full lift and medium sling. The care plan intervention to utilize the stand assist lift remained on the care plan without an end date. R1's progress notes dated 6/22/26 at 4:50 p.m., indicated R1 was transferred to the emergency department on 6/12/26 for a skin tear, and was changed from a stand assist lift to a full lift on 6/11/26. During an interview on 6/29/26 at 11:05 a.m., the FM-A stated that after R1 was injured using the stand assist lift on 6/12/26, the staff started to use	20565	Continued from page 2 assessment and CNA care guide. Licensed nurses and IDT members responsible for care plan updates were re-educated on the facility's Care Plan Policy, including the requirement to update care plans after any change and remove outdated interventions. Weekly audits will be completed on 15% of all residents for four (4) weeks, then monthly for two (2) months, to verify the transfer assessment, care plan, and CNA care guide are consistent and that outdated transfer interventions have been removed. The results of these audits will be reviewed by the facility Quality Assurance and Performance Improvement (QAPI) committee for ongoing compliance. The Clinical Administrator and or designee is responsible for ongoing compliance. Date certain for compliance is 7/16/2026	07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Arden Hills	**3220 LAKE JOHANNA BOULEVARD , ARDEN HILLS, Minnesota, 55112**

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20565	Continued from page 3 a full lift. During an interview on 6/29/26 at 1:03 p.m., the registered nurse (RN)-A stated R1's ability to transfer using a stand assist lift was reassessed on 6/11/26 because staff were concerned about her ability to transfer safely. R1 was assessed and subsequently required a full body lift. The change was indicated on R1's care sheet utilized by the nursing assistants (NA) and on R1's care plan. The RN-A acknowledged when R1's care plan was updated to indicate use of the full body lift, the intervention to utilize the stand assist lift was not removed and an end date was not added. During an interview on 6/29/26 at 2:27 p.m., the licensed practical nurse (LPN)-A stated R1's transfer status was assessed on 6/11/26 and was changed from a stand aid lift to a full body lift because she was no longer able to stand for 8 seconds, had bruising on her lower extremities because she could not bear weight and had to lean heavily on the lift. The LPN-A stated he added the full body lift to R1's care plan and acknowledged he did not remove the stand aid lift from R1's care plan or add an end date, which could be confusing for staff. During an interview on 6/29/26 at 4:03 p.m., the nursing assistant (NA)-A stated if the correct lift was not utilized, accidents during transfers of residents could happen. During an interview on 6/29/26 at 4:32 p.m., the director of nursing (DON) stated any discrepancy in the care plan could be a problem for a resident and acknowledged the care plan was updated with new information for R1's transfers, but the information about the previous transfer status had not been removed and an end date was not added. The Care Plan Policy and Procedure dated 11/22, indicated changes to the care plan would be made as necessary resulting from significant changes in condition or needs and should be current at all times. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are updated for residents who require lifts for transfers when the needs change. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	20565		07/16/2026

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20565	Continued from page 4 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	20565		07/16/2026