Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 25, 2025

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

RE: CCN: 245424
Cycle Start Date: June 25, 2025

Dear Administrator:

On June 6, 2025, 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 actual harm that was not immediate jeopardy (Level G),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

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

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	C 06/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/5/25 through 6/6/25, 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 H54245227C (MN00113213), with a deficiency cited at F689 at HARM PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, harm was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate supervision and scheduled toileting to reduce the risk for falls for 1 of 3 residents (R1) who had a history of falls. This resulted in actual harm for R1 who had an unwitnessed fall requiring emergency department (ED) services, sustained a laceration	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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F 689	Continued From page 1 to the head, received five staples, and was admitted to the hospital for further observation. The facility implemented corrective action prior to the survey so the deficient practice was issued at past non-compliance. Findings include: R1's admission Minimum Data Set (MDS) dated 3/12/25, identified diagnoses of severely impaired cognition without behaviors and lower impairment of range of motion (ROM) on one side, repeated falls, hip fracture, weakness, and shortness of breath), Alzheimer's, and dementia. R1 required supervision/touching with oral and personal hygiene, frequently incontinent of bowel and bladder, and verbal cues or touching/steadying with ambulation up to 150 feet, partial/moderate assistance with toileting hygiene, shower/bathe, upper body dressing, bed mobility, and all transfers. R1 had increased risk of falls identified due to medication use, intracerebral hemorrhage, muscle weakness, and difficulty walking. R1's physical therapy discharge summary dated 5/12/25, identified she required supervision or touching assistance to sit to stand, transfer from chair to bed, bed to chair and to toilet, and walked up to 150 feet. R1's care plan dated 6/5/25, identified the following fall interventions: -alert resident to changes to environment, 3/7/25 -place call light within reach, and answer promptly. 3/7/25 - keep in commons area, 3/12/25 -Night toileting between 10:00 and 11:00 p.m. 2:00 and 3:00 a.m., and 5:00 and 6:00 a.m. and as needed (PRN). 3/20/25	F 689		

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F 689	Continued From page 2 -place assistive device within reach, 3/20/25 -assure she had anti-rollbacks on wheel chair, 4/14/25 -place walker in closet with not in use, 4/14/25 -close blinds at night (unless request to keep open), 4/17/25 -dementia clock within view, 5/2/25 room re-arranged bed next to wall, 5/2/25 -assist to toilet every morning, before meals and at bedtime (HS), 5/15/25 -reposition and toilet her with assistance of one every three hours during the day and as needed (PRN). 5/15/25 -make up bed upon rising, 5/21/25 -push fluids in between meals/aim for 49 ounces, 5/23/25 -use lavender patches for a calming effect if she became restless or tried to stand up, 5/30/25 -five pound weight blanket with sequins, 6/4/25 R1's toileting record for 5/18/25 identified only the following times: -at 4:51 a.m. toileted with extensive assistance. -at 9:29 p.m. toileted with limited assistance. R1's progress notes from 5/18/25 through 5/21/25, identified: -on 5/18/25 at 9:10 a.m., around 8:05 a.m. she was found on the floor in a sitting position beside her bed. She said, "I'm making my bed". She was not capable of standing up on her own and was transferred safely with assistance of two staff with the use of a lift machine to her wheelchair without injury noted. Intervention based on root/cause analysis: She was aware that she was on the floor and said she just wanted to make her bed. Had tendencies of ending up on the floor because she wanted to do something. Had a history of falling multiple times without witness. Bring her to	F 689		

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F 689	Continued From page 3 common area or nurse's station where she can be monitored most of the time to minimize her falls. -on 5/18/25 at 8:49 p.m., she was found in bathroom on the floor bleeding from her head, conscious and alert. She said she tried to use to the bathroom. She was transferred out of the bathroom into wheelchair. Received orders to send to local hospital. (progress note lacked information related to R1's continence status when found) -on 5/18/25 at 9:54 p.m., she was sent to local hospital via ambulance left at approximately 9:00 p.m. -on 5/19/25 at 4:14 p.m., she returned from hospital at 3:50 p.m. -on 5/21/25, at interdisciplinary team (IDT) met on 5/19/25 and reviewed fall she had on 5/18/25 at 8:40 p.m., where R1 was found in her bathroom with a laceration to her head. Intervention based on root cause analysis: she was assisted off the floor with a lift machine by staff. Neuros initiated, range of motion (ROM) and vitals done. She was sent to local hospital and came back with new order for antibiotic for diagnosis of cystitis (inflammation of the bladder usually caused by infection) without hematuria (blood in the urine). Care plan reviewed and remained appropriate. R1's camera footage for 5/18/25, and viewed by director of nursing (DON) identified: -at 4:24 p.m. at nurse's station and taken to her room. -at 4:32 p.m. she came out of her room and placed at nurse's station.	F 689		

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F 689	Continued From page 4 -at 4:50 p.m. she was taken to the dining room. -at 6:20 p.m. staff brought her to the nurse's station from the dining room. -at 8:22 p.m. she went back to her room. -at 8:31 p.m. staff walked into her room and then left. -at 8:35 p.m. staff walked into her room again (most likely when she fell). -at 8:36 p.m. another staff walked into the room followed by another staff shortly after. -at 8:55 p.m. she was brought to nurse's station. -at 9:21 p.m. emergency medical services arrived (EMS). R1's ED provider note dated 5/18/25, identified 86-year-old female currently resides in the memory care unit with a history of notable major neurocognitive disorder due to multiple etiologies and multiple falls with head injuries including bilateral traumatic subdural hematoma (SDH). She presented today with an unwitnessed fall in the bathroom earlier tonight, found by a staff unaware how long she had been down but believed it to be less than two hours. She was unable to recall how or why she fell but did not believe she lost consciousness. She had a laceration to the back of the head and reported pain, some blood in her mouth but believed she had a bloody nose earlier on. Her family member noted that she usually walked with assistance but on occasion tried to walk on her own and frequently fell. Physical exam revealed a laceration that measured 4 centimeters (cm) by 3 cm located on the crown of her scalp. A local anesthetic, Lidocaine 1% with epinephrine (used to cause numbing or loss of feeling) was used prior to the application of five staples for skin repair and antibiotic ointment was applied.	F 689		

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F 689	Continued From page 5 R1's hospital discharge summary dated 5/19/25, identified she was admitted to hospital under observation for unwitnessed fall and work up related acute kidney injury. Her urinalysis was abnormal and treated with an antibiotic for a possible urinary tract infection (UTI). She was discharged back to the facility on 5/19/25 at 3:30 p.m. Facility investigation report summary submitted on 5/23/25 at 12:16 p.m., identified camera reviewed showed nursing assistant (NA) did not follow R1's plan of care. R1 was not taken to the bathroom after the initial toileting time of 4:30 p.m. NA reported was busy with two other residents, went back to nurse's station to check on R1, reading a book, assumed she was ok. She assisted another resident, came back and found R1 on the floor in the bathroom at 8:40 p.m., sent to ED, sustained a head laceration repaired with five staples, diagnosed with a possible UTI, and treated with antibiotics. (R1 left common area without redirection to return for supervision and was not toileted at 7:30 p.m.) R1's staff care sheet dated 6/3/25 identified toilet/reposition every three hours and PRN, every a.m., before meals, HS/night; 10:00 p.m. to 11:00 p.m. 2:00 p.m. to 3:00 p.m., and 5:00 p.m. to 6:00 p.m. and PRN. During an interview on 6/5/25 at 12:43 p.m., family member stated R1 was able to occasionally make her needs known, unable to use call light, and may have taken herself to bathroom rather than wait for help. She was unable to recall the day before events. R1 had received really good care at this facility and the only time she had concerns about her care was	F 689		

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F 689	Continued From page 6 when she fell on 5/18/25, and had not been toileted after 4:30 p.m. She felt like there had been some problem solving difficulties and a plan of care where she required eyes on her and should have not been left alone in her room. She was not toileted in a timely manner, had to go to the bathroom, self-transferred, was most likely what caused the fall. During an interview on 6/5/25 at 4:00 p.m., registered nurse (RN)-A stated R1 was at risk for falls, was not the best historian, and unsure if it would have been sensical (logical). Staff were expected to follow her care plan: toilet every three hours and kept within site in common area. R1 refused occasionally; staff were expected to have reproached her at least twice within 15 minutes maximum. The care plan was not followed on 5/18/25 and R1 should have been toileted within a three-hour time period, had taken herself into the bathroom, self-transferred, fell and hit her head. RN-A indicated she attempted to assess R1's head injury but was unable to see wound, the entire back of her head continuously bled, and stuck to her head/hair. She held pressure to the wound, was sent to hospital for treatment, and received five staples to the laceration. R1 had factors of dementia and a UTI but basically the fall could have been prevented if the care plan would have been followed. During an interview on 6/5/25 at 4:20 p.m., NA-A stated R1 was a high risk for falls and unable to make her needs known. Staff were expected to anticipate her needs and follow her care plan to prevent falls. Her care plan indicated she was to be toileted every three hours. On 5/18/25, R1 was last taken to the toilet at 4:30 p.m., she assisted other residents and when finished was unable to	F 689		

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F 689	Continued From page 7 find her at nurse's station so NA-A stated she went to her room and found R1 on the floor in the bathroom near the sink with a medium amount of blood on her head and clothing. R1 was responsive, had increased confusion, and told her she wanted to go to the toilet. NA-A indicated she had seen R1 last at 7:00 p.m. located by the nurse's station reading a book. She would have been expected to toilet her by 7:30 p.m., did not follow care plan, and could have avoided the fall if care plan would have been followed. NA-A added, R1 was injured, sent to ER, diagnosed with a UTI and received five staples to her head. She had received education the following day, communicate with nurse if unable to toilet a resident, always ask for help if needed, follow care plan, and carry the care sheets with her at all times. During an interview on 6/6/25 at 10:15 a.m. clinical coordinator RN-B stated R1 was at risk for falls, forgetful, and would attempt to self-transfer. Staff were expected to anticipate her needs so falls could be prevented. She most likely stood up, tried to self- toilet herself, and fell which resulted in a laceration with five staples. The care plan was not followed, R1 should have been toileted every three hours and was not within the appropriate time frame. She was impulsive and the fall may have been prevented if supervised in common area and toileted earlier. During interview on 6/6/25 at 11:20 a.m., DON stated R1 was at risk for falls and could make her needs known depending on the day. She reviewed R1's camera footage after her 5/18/25 fall in the evening and at 8:22 p.m., R1 was seen reading a book in her wheelchair located at the nurse's station. The nurse left the area and R1	F 689		

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F 689	Continued From page 8 had taken herself back to her room. DON added, part of her care plan is to keep her in common spaces but she independently wheeled back to her room. At 8:31 p.m. staff walked into her room and out again, unknown why, and at 8:35 p.m. staff entered her room here R1 was found on the floor in the bathroom. Staff would have been expected to have followed the care plan, toileted her, and placed her into bed. Because R1 was found in the bathroom, it is assumed she had tried to toilet herself but then fell. The fall could have prevented if she had been toileted per the care plan but with her history of falls, that is hard to say. R1 sustained a laceration to the head, was sent to the hospital via ambulance, received medical care, five staples to her head, diagnosed with acute cystitis/UTI and started on an antibiotic. She was notified that evening after the fall. The staff education was initiated on 5/22/25, presented via stand up (a daily meeting held on the floor by the managers) and the majority of the nursing staff on 4th floor had received fall prevention education by 5/23/25. The education document identified this was a recent incident in which a resident suffered an injury due to their care plan not being followed. All nursing staff were responsible for knowing and following the plan of care for the residents there were responsible for. Care sheet must be carried with nursing staff at all times. Facility policy Care Plan dated 11/2022, revealed the care plan identified needs for supervision, behavioral interventions, assistance with activities of daily living (ADLs) as necessary and individualized to meet the resident's needs.	F 689		

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F 689	Continued From page 9 Facility policy Fall Prevention and Management Program dated 4/2021, identified the purpose of the policy was to assign responsibility and provide procedure for residents at risk for falls; to systematically assess fall risk factors; provide guidelines for fall and repeat fall preventive interventions; and outline procedures for documentation and communication. A fall was defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface and maybe witnessed, reported by the resident or an observer or identified when a resident was found on the floor or ground. The resident's care plan must be individualized and implement interventions according to resident specific risk factors by nursing staff to help prevent falls and provide a safe environment of care.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 25, 2025

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

Re: Event ID: 399211

Dear Administrator:

The above facility survey was completed on June 6, 2025 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/5/25 through 6/6/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed:	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00975	A. BUILDING: _____ B. WING _____	C 06/06/2025

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

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2 000	Continued From page 1 H54245227C (MN00113213). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		