DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 20, 2022

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

RE: CCN: 245556
Cycle Start Date: June 16, 2022

Dear Administrator:

On July 18, 2022, the Minnesota Department(s) 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
June 27, 2022

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

RE: CCN: 245556
Cycle Start Date: June 16, 2022

Dear Administrator:

On June 16, 2022, 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:

- 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:

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 16, 2022 (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 16, 2022 (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, 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
	245556	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(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 6/14/22, to 6/16/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H55562247C (MN84201), with deficiencies cited at F678. 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.	F 000		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to respond appropriately to 1 of 1 residents (R1) when staff initiated cardiopulmonary resuscitation (CPR) 20 minutes	F 678	F678 Cardio-Pulmonary Resuscitation Immediate Corrective Action: RN-A and LPN-A were immediately re-educated on	7/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/06/2022

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

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F 678	Continued From page 1 after R1 was determined to have no pulse, had rigor mortis (stiffening of the muscles; considered a clinical sign of irreversible death) indicating CPR would not be effective or appropriate. Findings include: R1's Admission Record dated 6/15/22, indicated R1 admitted to the facility on 6/9/22, with diagnoses of acute myocardial infarction (heart attack) resulting in coronary bypass (CABG) surgery, heart failure, atrial fibrillation (irregular heartbeat resulting in clots), kidney failure, diabetes, malnutrition, anemia (low red blood cells), heart disease, and high blood pressure. R1 was admitted to the facility Transitional Care Unit (TCU) for cardiac rehabilitation after surgery on 6/1/22. R1's Minimum Data Set (MDS) dated 6/9/22, lacked information due to R1's recent admission. R1's Interagency Physician Discharge Orders/Instructions dated 6/9/22, at 12:45 p.m. indicated R1 was a full code (wanted CPR initiated if R1 stopped breathing and had no pulse). R1's admission Progress Note dated 6/9/22, at 6:04 p.m. indicated R1 was alert and oriented with forgetfulness. R1 was able to stand and pivot and required an assist of one staff member for transfers. R1's care plan dated 6/9/22, indicated R1 had limited mobility and would be free from thrombus (blood clot) formation. Interventions included assistance of one staff with a gait belt for transfers. R1 had a POLST with advanced	F 678	the facility CPR policy, including exclusions on when CPR would not be indicated (rigor mortis, dependent lividity, decapitation, transection, or decomposition). Corrective Action as it Applies to Other Residents: The CPR policy was reviewed and revised to include steps a nurse would take to initiate CPR. All facility nurses were re-educated on the facility CPR policy. A facility audit of POLSTs was completed on 6/10/22 to identify other residents that may be at risk for outdated POLSTs. Any POLSTs found to be either missing or outdated were updated to reflect their current Code Status. Monthly mock code drills will be completed to verify understanding. Reoccurrence will be Prevented By: The Clinical Administrator or designee will complete weekly audits x5 to ensure that all facility nursing staff understand the CPR policy for 8 weeks. The Quality Assurance Committee will determine ongoing need for audits. The Administrator is responsible for compliance. Date Certain: 7/11/2022.	

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F 678	Continued From page 2	F 678		

directives he wanted honored and wished to discharge from the facility by 9/7/22.

R1's POLST dated 6/9/22, indicated R1 wanted CPR performed in the event he was not breathing and had no pulse.

R1's Physician Orders dated 6/9/22, indicated R1 was a full code.

R1's progress note dated 6/10/22, indicated at approximately 6:50 a.m. licensed practical nurse (LPN)-A observed R1 was not breathing and did not have a pulse. Registered nurse (RN)-A confirmed R1 did not have a pulse, called 911 and began CPR.

During an interview on 6/14/22, at 11:01 a.m. a police dispatcher stated 911 was called at 7:10 a.m.; 20 minutes after R1 was found without a pulse. A police officer arrived at the facility at 7:13 a.m.

During an interview on 6/14/22, at 11:08 a.m. an emergency medical (EMS) dispatcher stated on 6/10/22, at 7:11 a.m. EMS was notified CPR was being started on an unresponsive resident at the facility. EMS arrived at the facility at 7:17 a.m. and pronounced R1 dead at 7:23 a.m.

Review of RN-A's written statement dated 6/13/22, indicated on 6/10/22, at 6:50 a.m. LPN-A and RN-A found R1 lying in his bed with no pulse and not breathing. According to the written statement, LPN-A called the administrator to report the resident's death, then RN-A noted R1 was a full code, LPN-A and RN-A transferred R1 to the floor using a sheet. RN-A indicated R1's neck was stiff and did not drop during the transfer

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F 678	Continued From page 3	F 678		

and his extremities were cool with "some rigor". Despite the presence of rigor mortis, LPN-A called 911 and assisted RN-A in performing CPR on R1 until the emergency medical services (EMS) arrived. RN-A indicated EMS stopped life saving efforts shortly after arrival because R1 had levity [lividity] (pooling of the blood in the lowest parts of the body which is considered a clinical sign of death indicating CPR would not be effective or appropriate).

During an interview on 6/14/22, at 3:13 p.m. LPN-A stated on 6/10/22, at 6:50 a.m. NA-A stopped her as she was leaving for the day and told LPN-A she didn't think R1 was breathing. LPN-A shook R1, called his name and gave him a "very hard sternal rub which should have sent him screaming". When R1 did not respond, LPN-A called out for RN-A who took R1's temperature and assessed R1 did not have a pulse. LPN-A left R1's room to call the director of nursing (DON) and the administrator and RN-A left R1's room to read the procedure for a resident who died in the facility less than 24 hours after admission. After reading the procedure, RN-A checked R1's code status and found him to be a full code. LPN-A the two nurses returned to R1's room where they lifted him from his bed onto the floor. LPN-A then called 911 and texted the administrator who responded "Good. We have to try". RN-A and LPN-A started CPR; however, they did not get the facility's automated external defibrillator (AED, a device used in conjunction with CPR for the best chance of survival during cardiac arrest). LPN-A stated nursing staff received training on how to perform CPR.

During an interview on 6/14/22, at 11:42 a.m. RN-A stated she did not know if there was a

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F 678	Continued From page 4 facility procedure for how to take care of a resident in cardiac arrest (not breathing and without a pulse) and that there was no "perfect process". RN-A stated on 6/10/22, at 6:50 a.m. she was alerted by LPN-A that R1 was "gone". RN-A went to R1's room and found him lying in his bed with his arms at his side and his head tilted to the right with blankets pulled over his chest. R1's arm was "cool but not ice cold", he was not breathing and did not have a pulse. LPN-A left to call the director of nursing (DON) and the administrator. RN-A stated after 7:00 a.m. she checked R1's code status and realized he was a full code. RN-A advised LPN-A and they returned to R1's room and transferred R1 onto the floor next to his bed. LPN-A then called 911 and RN-A started CPR. RN-A also stated they did not think to get the facility AED. RN-A stated it did not occur to her at the time, to check R1's code status immediately after assessing R1 had no pulse because R1 "looked so gone"; however, RN-A did not identify any obvious signs that indicated she should not have initiated CPR and used the AED. RN-A further stated when EMS arrived, they pronounced R1 dead at 7:23 a.m. stating R1 had signs of dependent "levity" [lividity]. RN-A stated she did not know what that was and responded, "What is that?". Although RN-A's statement to the facility indicated R1 had rigor mortis, RN-A did not identify it as a reason for the delay in initiating CPR during the interview. Instead, RN-A stated, she did not "go into the mode" that R1 did not have a pulse, requiring her to check his code status. RN-A also did not identify rigor mortis as an irreversible sign of death, resulting in CPR being ineffective and unnecessary. During an interview on 6/14/22, at 11:34 a.m.	F 678		

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F 678	Continued From page 5 RN-B stated she was agency staff and received CPR training through the American Red Cross and did not receive any CPR training from the facility. RN-B stated she would start CPR right away on a resident who had no pulse and was a full code. RN-B stated she would ask another staff member to bring the facility AED but applying an AED was not automatic and RN-B would not use it unless she "felt it could help". RN-B was unable to specify circumstances she felt an AED would or would not be useful. During an interview on 6/15/22, at 9:14 a.m. LPN-B stated "a few days ago" she was instructed to review the facility policy on where to find a resident's POLST and to check a resident's code status immediately after finding them with no pulse and not breathing. LPN-B stated there was no training on the specific steps for providing CPR and did not know what the procedure was. LPN-B stated she would "probably" get on the Walkie talkie and ask for help and for someone to bring the resident's chart to her if she found a resident with no pulse and not breathing. During an interview on 6/15/22, at 9:29 a.m. RN-C stated they reviewed the facility CPR policy about an hour ago with the DON. RN-C was instructed if a resident was found without a pulse and was a full code, the staff were to start CPR right away, get the AED and continue CPR until EMS arrived. RN-C further stated EMS would then determine whether CPR should continue or be stopped based on an assessment for clinical signs of death including dependent lividity and/or rigor mortis. During an interview on 6/14/22, at 1:28 p.m. the director of nursing (DON) stated when staff find a	F 678		

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F 678	Continued From page 6 resident who was not breathing and did not have a pulse, they should look at the resident's POLST in their chart and if they are full code, initiate CPR, call 911 and get the AED immediately. The DON stated if staff did not see obvious signs of clinical death, she would not expect them to roll a resident over and undress them to look for dependent lividity when determining whether to perform CPR on a resident who was full code. The DON further stated the facility Cardiopulmonary Resuscitation (CPR) policy dated December 2014, was the only facility policy she was aware of. During an interview on 6/15/22, at 8:54 a.m. the DON stated she did not know the content of the training the nursing staff received on 6/10/22, after R1 died, however, when she arrived at 6:00 a.m. today, she began reviewing the facility CPR policy with the nursing staff. The DON, also advised staff it was not their responsibility to determine whether a resident had dependent lividity or rigor mortis and they were to initiate CPR and continue until EMS arrived. The nursing staff were also to begin CPR immediately upon assessing a resident had no pulse, then call out for other staff to check the code status of the resident. If the resident had a do-not-resuscitate (DNR) order, staff were to stop CPR. The DON stated because that procedure was not in the facility policy, nursing staff were giving her "some push back" about not checking the resident's code status before initiating CPR. The DON stated although that was not in the policy, she did not want any delay in a resident receiving CPR. The DON stated there was no new or revised CPR policy or procedure created since 6/10/22. During an interview on 6/14/22, at 4:07 p.m. the	F 678		

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F 678	Continued From page 7 administrator stated staff were expected to review a resident's code status immediately after determining they were not breathing and had no pulse. The administrator also stated staff did not follow the facility procedure and should have initiated CPR and called 911 immediately after determining R1 had no pulse and was full code. The administrator further stated the facility Cardiopulmonary Resuscitation (CPR) policy dated December 2014, was the only policy on CPR that he was aware of. Review of the facility Cardiopulmonary Resuscitation (CPR) policy dated December 2014, indicated PHS (Presbyterian Homes and Services) provided American Heart Association CPR classes to nursing working in campuses located in Minnesota. The policy indicated if a resident was found in cardiac arrest, the facility must provide CPR, prior to the arrival of EMS, according to the resident's advanced directives, and in the absence of obvious signs of clinical death (e.g. rigor mortis, dependent lividity).	F 678		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 27, 2022

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

Re: Event ID: DDMQ11

Dear Administrator:

The above facility survey was completed on June 16, 2022 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