DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 6, 2022

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: CCN: 245613
Cycle Start Date: May 25, 2022

Dear Administrator:

On July 5, 2022, the Minnesota Department of Health and Public Safety 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 6, 2022

CMS Certification Number (CCN): 245613

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 28, 2022 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all skilled nursing facility beds 60.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 2, 2022

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: CCN: 245613
Cycle Start Date: May 25, 2022

Dear Administrator:

On May 25, 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:

Sarah Grebenc, 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: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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 August 25, 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 November 25, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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
	245613	A. BUILDING _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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
E 000	Initial Comments On 5/22/22 through 5/25/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/22/22 through 5/25/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 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 substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		6/28/22

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

Electronically Signed | 06/10/2022

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 684	Continued From page 1 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow an intervention to prevent bruising for 1 of 2 residents (R26) reviewed for non-pressure related skin concerns. Findings include: R26's diagnoses included stroke affecting left side, chronic kidney disease, diabetes, and non-pressure chronic ulcer of the calf obtained from the admission record printed on 5/25/22. R26's quarterly Minimum Data Set (MDS) dated 3/27/22, indicated R26 had moderate cognitive impairment and required extensive assist of one staff for activities of daily living. R26's care plan with a revision date of 4/7/22, indicated R26 had venous stasis ulcers (abnormal vein function) on left shin and was at risk for further skin impairment due to diabetes, impaired mobility, edema (excessive fluid trapped in the body's tissue), aspirin use, chronic kidney disease, left sided stroke, and medication side effects. R26's care plan with an initiated date of 4/6/22, further indicated R26 was to wear geri-sleeves (a product that protects the resident's arms) or stockinette to bilateral hands/arms during the day and were to be	F 684	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F684, F686, and F759. However, submission of this Plan of Correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. F684- Based on observation, interview and document review, the facility failed to follow an intervention to prevent bruising for 1 of 2 residents (R26) reviewed for non-pressure related skin concerns. "Resident (R26) plan of care has been reviewed and remains appropriate. "Resident has been provided a pair of stockinette and Geri sleeves to be used as specified in the plan of care. Facility continues to monitor the skin of (R26) through weekly body audits with no new findings. "An audit was completed on all residents to ensure care planned skin prevention measures are in place. "The Skin Integrity Management Policy was reviewed and remains up to date. All nursing staff were reeducated on the Skin	

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F 684	Continued From page 2 removed at night. On 5/22/22, at 12:32 p.m. R26 was observed wearing a short sleeve shirt, no protective sleeves or stockinettes in place. R26 was observed having multiple bruises to bilateral arms, the bruises extended from the elbows to the top of her hands. R26 indicated not knowing where the bruises came from. On 5/24/22, at 10:56 a.m. R26 was observed wearing a short sleeve shirt with no protective sleeves or stockinettes in place. A Progress Note dated 5/19/22, indicated R26 had a 5.2 centimeter by 3 centimeter bruise to her right forearm. The Progress Note further directed R26 could wear geri-sleeves to bilateral upper arms. A Body Audit dated 5/17/22, indicated R26 had bruises to left and right forearms and that all bruises were at different stages of healing. During an interview on 5/24/22, at 10:57 a.m. nursing assistant (NA)-G indicated R26 had stockinettes for her legs but not for her arms. During an interview on 5/24/22, at 1:08 p.m. R26 indicated she had never been told to wear anything to her arms, or that she had to wear long sleeve shirts. R26 stated she preferred both short and long sleeve shirts. During an interview on 5/24/22, at 1:53 p.m. NA-G verified on the nursing assistant care sheets that R26 was to have geri-sleeves or stockinettes applied to her bilateral arms. NA-G then stated "I have not seen them, but I will go	F 684	Integrity Management Policy. "Facility followed up with staff that were identified as not following the plan of care for education. "The facility will complete random audits of 10% of residents using their care sheets to ensure their services provided match the care sheet/care plan weekly to ensure ongoing compliance with cares and services for six weeks. The results of these audits will be reviewed by the Quality Assurance team to determine the frequency of ongoing audits. "The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is June 28, 2022.	

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F 684	Continued From page 3 look." NA-G then enters R26's room and asked "do you ever wear geri-sleeves or long sleeves on your arm." R26 replied with "yeah sometimes." NA-G then proceeded to look around R26's room and indicated she could not find any geri-sleeves or stockinettes for R26's arms. During an interview on 5/24/22, at 1:59 p.m. licensed practical nurse (LPN)-A indicated staff should be following the care plan, and should be attempting to put the geri-sleeves or stockinettes on R26 as the care sheets indicated. During an interview on 5/24/22, at 2:06 p.m. director of nursing (DON) indicated the geri-sleeves or stockinettes should be used or at least attempted to be applied to R26's arms. The facility's Skin Integrity Management Policy dated 6/21, directed a care plan will be developed or modified to reflect alterations in interventions and implementation of new interventions specific to the resident. The policy further directed the care plan interventions will be communicated to the appropriate staff via the nursing assistant assignment sheet or My Best Day and/or through report.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		6/28/22

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F 686	Continued From page 4 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to reposition or off load a resident timely, who had an unhealed pressure ulcer, without evidence of decline for 1 of 1 resident (R47) reviewed for pressure ulcers. Findings include: R47's annual Minimum Data Set (MDS) dated 4/19/22, indicated R47 was severely cognitively impaired and required extensive assistance by two staff for bed mobility, transfers and toileting. R47's MDS further indicated R47 was always incontinent of both bowel and bladder. R47's diagnoses included dementia, Meningioma (noncancerous tumor involving the brain and spinal cord), major depressive disorder, anxiety, seizures, weakness and dorsalgia (spinal/back pain). R47's Pressure Ulcer Care Area Assessment (CAA) dated 4/19/22, indicated R47 required assistance for bed mobility, pressure ulcer and incontinence and had a stage 3 (full-thickness skin loss) pressure ulcer on coccyx. R47's CAA further indicated "Braden score 13 indicating risk for skin breakdown." R47's care plan (CP) last revised 5/12/22, indicated R47 had a pressure injury to coccyx and was at risk for further impaired skin integrity due	F 686	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F684, F686, and F759. However, submission of this Plan of Correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. F686- Based on observation, interview and document review the facility failed to reposition or off load a resident timely, who had an unhealed pressure ulcer, without evidence of decline for 1 of 1 resident (R47) reviewed for pressure ulcers. To ensure compliance: "R47 was reassessed to ensure that the repositioning plan of care and repositioning schedule remains appropriate. Facility continues to monitor the skin of (R47) through weekly body audits with no new findings. "An audit was completed on all residents to ensure the repositioning plan of care and repositioning schedule is accurate and remains appropriate "The facility has reviewed the skin management policy and it remains effective. All nursing staff were	

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F 686	Continued From page 5 to a history of "impaired skin, decreased mobility, decreased nutritional intake, weight loss, cognitive impairment, palliative cares, med SEs [medication side effects], incontinence/moisture, advanced age and Braden score indicating risk." R47's CP directed staff to check or change brief and reposition every three hours. R47's Skin and Wound Evaluation dated 5/18/22, indicated R47 had a stage 3 pressure ulcer on coccyx with progress noted as stable. Treatments listed include wound cleanser, dressing, cushion, incontinence management, mattress with pump, nutrition/dietary supplementation, and turning/repositioning program. R47's Skin and Wound Evaluation dated 5/25/22, indicated R47 had a stage 3 pressure ulcer on coccyx with progress noted as stable. Treatments listed include wound cleanser, dressing, cushion, incontinence management, moisture barrier, mattress with pump, nutrition/dietary supplementation, and turning/repositioning program. The Maple Ridge unit nurse aide care sheet (CS) last updated 5/16/22, indicated R47 required assistance of two staff using a full lift for transfers. The CS directed staff to toilet and reposition R47 every three hours. The CS's attached Toilet/Reposition Tracking Sheet for 5/23/22, indicated R47 was toileted and repositioned at 8:05 a.m. and 11:00 a.m. On 5/23/22, at 11:17 a.m. R47 was observed sitting up in wheelchair (WC) in room, fully dressed and groomed.	F 686	reeducated on the policy. "The facility will complete random audits of 10% of residents using their care sheets to ensure their services provided match the care sheet/care plan weekly to ensure ongoing compliance with cares and services for six weeks. The results of these audits will be reviewed by the Quality Assurance team who will determine the frequency of ongoing audits. "The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is June 28, 2022.	

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F 686	Continued From page 6 During continuous observation on 5/23/22, from 11:56 a.m. to 3:23 p.m., R47 was not repositioned timely. -At 11:56 p.m. R47 was pushed into the dining room in WC for lunch. -At 12:39 p.m. nursing assistant (NA)-D pushed R47 back to room and overheard asking R47 if he wanted to return to bed. R47 stated he did want to lay in bed. NA-D told R47 that since he was an assist of two staff for transfers, she would go get help and return. R47 asked how long it would take and NA-D stated someone would return in five minutes or so. R47's door was left open. -At 1:02 p.m. trained medication aide (TMA)-A walked to refrigerator in small dining room across from R47's room. TMA-A did not enter R47's room. -At 1:13 p.m. NA-F entered and sat in the small dining room across from R47's room and did not approach R47's room. -At 1:30 p.m. no staff had entered R47's room. R47 still sitting in WC. Room was dark and quiet. R47's eyes were closed, and he appeared to be sleeping. -At 1:39 p.m. NA-A entered R47's room and approached the small kitchen area of the room behind and to the right of where R47 sat. NA-A exited the room within 10 seconds and did not approach or speak to R47. When interviewed upon exit, NA-A stated she just had to drop something off in his room. -At 2:00 p.m. no staff had entered R47's room. R47 still sat in WC. -At 2:21 p.m. NA-B and NA-C walked down hallway and sat in common area just outside R47's room. NA-B stated they were reviewing care sheets left by the previous shift's staff. NA-B further stated typically they would talk to previous	F 686		

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F 686	Continued From page 7	F 686		

shift for report off, but if they do not see staff from previous shift will just look at care sheets. Today neither NA-B nor NA-C received verbal report from NA-A.
-At 2:30 p.m. NA-B and NA-C leave common area and walk toward main dining area. No one approached or entered R47's room.
- At 2:59 p.m. NA-B and NA-C exited a different resident's room and walked past R47's without entering R47's room.
-At 3:16 p.m. no staff had entered R47's room.
-At 3:19 p.m. NA-B and NA-C entered R47's room with a full mechanical lift, attached sling and prepared R47 for transfer to bed.
-At 3:23 p.m. R47 was lifted off the WC and transferred into bed. R47 was incontinent of stool. NA-A completed a brief change and peri care. R47's bottom and back of thighs were reddened and wrinkled. A dressing covered R47's coccyx.

When interviewed on 5/23/22, at 3:38 p.m. NA-B stated R47 was last toileted and reposition at 11:00 a.m. according to the CS and that she normally checked on R47 every hour since he did not use the call light. When NA-B was asked how often R47 should be checked and repositioned, she stated, "every time." When NA-B was asked to specify frequency, she stated, "every three hours." NA-B confirmed R47 had not been repositioned timely according to the CS.

When interviewed on 5/23/22, at 4:14 p.m. registered nurse (RN)-A stated staff should follow the CP and CS. RN-A further stated if the CS instructed staff to reposition, check and change a resident every three hours, then it should be done as close as possible to that schedule.

When interviewed on 5/23/22, at 4:16 p.m.

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	245613	A. BUILDING _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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 686	Continued From page 8 director of nursing (DON) stated the expectation was that staff would provide care according to the CP. DON further stated that if a resident was on every three-hour repositioning and was last repositioned at 11:00 a.m., he would be due to be repositioned at 2:00 p.m. and should be the first resident cared for at the start of the evening shift. DON stated when staff tell a resident someone would return in five minutes and did not return for almost three hours, it was disappointing. DON further stated R47 should have been repositioned at the beginning of the evening shift and that four plus hours was too long in between re-positioning's. When interviewed via phone on 5/23/22, at 4:37 p.m. NA-A stated she changed and repositioned R47 twice during her shift that day with the last time being at 11:00 a.m. NA-E assisted with R47's 11:00 a.m. transfer to the WC. NA stated R47 did have a pressure ulcer and should be repositioned every three hours. NA-A further stated the 11:00 a.m. check and reposition was documented on the CS and that he was due for another check and reposition at 2:00 p.m. which would be the responsibility of the evening shift staff. NA-A further stated NA-D had assisted R47 with lunch and reported to her (NA-A) that R47 ate approximately 50 percent of his lunch. When interviewed on 5/24/22, at 8:43 a.m. NA-A stated R47 was changed on 5/23/22, at 8:00 a.m. and repositioned but remained in bed. NA-A further stated that on 5/23/22, at 11:00 a.m. R47 was changed, dressed, groomed, and transferred into his WC for lunch. NA-A stated never receiving report that R47 wanted to return to bed after lunch.	F 686		

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F 686	Continued From page 9 When interviewed via phone on 5/24/22, at 9:12 a.m. NA-D stated she helped R47 eat lunch on 5/23/22, and that she reported to NA-A that he ate 50 percent of his lunch. NA-D further stated she wheeled R47 back to his room after lunch and that R47 told her he was ready to go back to bed. NA-D stated she told R47 she would tell NA-A since he was a two person assist and that someone would be back in about five minutes. NA-D stated she provided R47 with his call light and thought he could use it pretty well. NA-D stated she reported to NA-A that R47 was ready to go back to bed and that NA-A responded she would go there after she finished cleaning up the lunch trays. When interviewed on 5/24/22, at 10:53 a.m. nurse practitioner (NP)-A stated R47's coccyx pressure ulcer status fluctuated as she will see a little improvement and then a decline but added that it was currently stable. When interviewed on 5/25/22, at 8:30 a.m. administrator stated nursing assistants received turning/repositioning and customer service training in orientation and annually. When interviewed on 5/25/22, at 11:08 a.m. DON stated that per facility policy, the expectation was residents should be repositioned per their CP and therefore, R47 should be repositioned every three hours. DON further stated that the Maple Ridge unit was well staffed on 5/23/22, so there should not have been a delay in transferring R47 back to bed per his wishes. DON stated going over the repositioning schedule by an hour was not acceptable. DON further stated he just completed wound rounds and R47's coccyx pressure ulcer was stable.	F 686		

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PRESBYTERIAN HOMES OF NORTH OAKS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

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F 686	Continued From page 10 Review of progress note by MD-A from 5/10/22, at 1:51 pm indicated, "[R47] Has known coccyx wound, followed by our wound care nurse. At least stable, not worsening." Facility policy Repositioning of Residents dated 9/2015, indicated, "All residents assessed as requiring assisted repositioning due to wounds, mobility concerns, etc., as identified in their Care Plan, will receive the required reposition by the nursing staff and will be monitored via the repositioning schedule." The policy instructed staff to "reposition resident per their plan of care and as needed or requested."	F 686		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders without errors for 1 of 6 residents (R31) observed to receive medications. This resulted in a facility medication error rate of 18% (percent). Findings include: R31's Medication Administration Report dated 5/1/22 through 5/31/22, identified R31 had orders for: -Amlodipine tablet 10 milligrams (mg) give 1	F 759	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F684, F686, and F759. However, submission of this Plan of Correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. F759- Based on observation, interview, and document review, the facility failed to ensure medications were administered in	6/28/22

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F 759	Continued From page 11 tablet via G-tube [gastric tube] one time a day for high blood pressure -Aspirin chewable tablet 81 mg give 1 tablet via G-tube one time a day for stroke prevent. -Carvedilol tablet 3.125 mg give 3.125 mg via G-tube two times a day for high blood pressure disorder. -Escitalopram Oxalate 10 mg tablet give 10 mg via G-tube one time a day for depression. -Tylenol extra strength 500 mg tablets, give 1000 mg via G-tube two times a day for pain. -Senna-Docusate Sodium tablet 8.6-50 mg give 1 tablet via G-tube one time a day for constipation. -Polyethylene Glycol 3350 give 17 gram (1 cap full) via G-tube in the morning for constipation. On 5/24/22, at 8:21 a.m. registered nurse (RN)-C was observed preparing R31's medications which included: - Aspirin 1 tablet (81 mg) - Carvedilol 1 tablet (3.125 mg) - Escitalopram Oxalate 1 tablet (10 mg) - Tylenol Extra Strength 500 mg (2 tablets- 1000 mg) At 8:36 a.m. RN-C was observed attempting to crush the listed medications for R31's together and administer the medications via G-tube. RN-C was stopped by the surveyor and was requested RN-C review R31's medication orders. RN-C stated after review of the medication orders "looks like they want them [medications] done one at a time." RN-C then indicated she was going to crush all the medications together and give the medications all at once. During an interview on 5/24/22, at 10:21 a.m. director of nursing (DON) indicated that a physician order would need to be obtained to	F 759	accordance with physician orders without errors for 1 of 6 residents (R31) observed to receive medications. This resulted in a facility medication error rate of 18% (percent). "Facility contacted pharmacist immediately to review medications regimen and give recommendation for appropriateness of medication dosage forms ordered in resident (R31) requiring crushing of medications. The pharmacists found that all medications for the resident (R31) to be appropriate to be crushed if needed to facilitate administration. "In addition, any or all these medications may be mixed together just prior to administration if needed to facilitate flushing via feeding tube with no expectation of adverse interaction. "Facility has also completed a comprehensive audit of all residents with orders to crush medications and consulted with the pharmacist for their appropriateness to be crushed and mixed together before administration. "The facility will complete random audits of 5% of residents with physician orders to crush medication weekly to ensure ongoing compliance with cares and services for six weeks. The results of these audits will be reviewed by the Quality Assurance team who will determine the frequency of ongoing audits. "The Enteral Tube Medication Administration policy was reviewed and remains up to date and all licensed nursing staff were reeducated on the policy. Facility will continue to monitor	

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F 759	Continued From page 12 administer medications all at once through a G-tube. During the interview the DON verified R31 did not have an order to administer the medications all at once. During at interview on 5/24/22, at 11:47 a.m. consultant pharmacist indicated medications should not be mixed together and administered through the G-tube without notifying pharmacy first due potential medication interactions. The facility's Enteral Tube Medication Administration policy dated 1/27/19, directed the individual administering the medication that each medication must be prepared separately and administered one at a time (unless otherwise ordered).	F 759	compliance during quarterly medication review. "The Clinical Administrator or designee will be responsible for ongoing compliance; the date of compliance is June 28, 2022.	

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	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/24/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/24/2022. At the time of this survey, Presbyterian Homes of North Oaks was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The facility was surveyed as one building. Presbyterian Homes of North Oaks is on the 1st floor (ground level) of a 3-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 2005 and was determined to be of Type II(111) construction. In 2008 a 3 story addition was constructed to the East and was determined to be of Type II(111) construction. The nursing home uses only the 1st floor and is fire separated from the other floors. The building is fire sprinklered throughout and also has a fire alarm system with smoke detectors in the corridors, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 56 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/10/2022

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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	245613	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/24/2022**

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K 000	Continued From page 1 MET.	K 000		