

Office of Health Facility Complaints Investigative Report PUBLIC

| Facility Name: Presbyterian Homes of Arden Hills Facility Address: 3220 Lake Johanna Boulevard | | | Report Number: H5424039 | Date of Visit: March 20, 2017 | | |
|---|-----------|--|--|------------------------------------|--|--|
| | | | Time of Visit: 8:30 a.m. to 4:00 p.m. | Date Concluded: October 9, 2017 | | |
| Facility City: Arden Hills | | Investigator's Name and Title: Peggy Boeck, RN, Special Investigator | | | | |
| State: | ZIP: | County: | | | | |
| Minnesota Nursing Home | 55112 | Ramsey ——————— | | | | |

Allegation(s):

It is alleged that a resident was neglected when the alleged perpetrator failed to follow the resident's care plan and transferred the resident without the use of a mechanical stand lift. The resident had a fall with a fractured/depressed area of the right knee.

- |X| Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ▼ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ▼ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect did occur. The alleged perpetrator (AP) did not use a gait belt or standing lift when s/he assisted the resident in the bathroom. The resident fell to the floor and broke a bone in his/her right knee.

The resident had been at the facility for less than one year and had recently been hospitalized for anemia. Due to weakness, the resident had not been able to walk for some time. The resident had difficulty moving his/her joints because of osteoporosis. The resident was alert, oriented, and able to make his/her needs known. The resident had been assessed to need assistance of one staff with a standing lift for transfers.

On the morning of the incident, the resident had turned on the call light to use the bathroom. The AP responded to the light and was with the resident when s/he fell from a standing position down to the floor, knees first.

When interviewed, a nurse stated s/he had gone into the resident's room that morning to give the resident medication. When the nurse walked past the resident's bathroom, s/he stated s/he saw a wheelchair in the bathroom with the resident and the AP standing next to it. The resident had both hands on the grab bar, which was attached to the wall to the right of the toilet. In the room, the nurse sat in a chair. The AP called for help and the nurse got up and went into the bathroom. The nurse said the resident was in the same position facing the wall, holding onto the grab bar, with the toilet on the resident's left and the wheelchair

Facility Name: Presbyterian Homes of Arden Report Number: H5424039 Hille on the right. The nurse saw the resident falling to his/her knees while holding the grab bar. The AP was standing behind the resident holding on to the resident by the fabric of the resident's pants on both sides at the waist. The nurse stated s/he did not see a gait belt on the resident and there was no standing lift in the room. The hospital record indicated the resident had a fracture of the tibia at the knee, but was not a candidate for surgery. The resident was discharged back to the facility with a knee immobilizer for the fracture and a prescription for narcotic pain medication. When interviewed, a family member stated they thought the resident required two staff for transfers at the time of the fall. When family visited the resident the next morning, the resident was in severe pain, and an ambulance was called. The family member said the hospital found a broken bone in the resident's right knee. When interviewed, the physician stated the resident was a high surgical risk due to his/her health. The resident's broken knee was not surgically repaired. The AP did not respond to requests for an interview. Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557) Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557): ☐ Financial Exploitation ☐ Abuse ☐ Not Substantiated ☐ Inconclusive based on the following information: Substantiated
 ■ **Mitigating Factors:** The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ⊠ Individual(s) and/or ☐ Facility is responsible for the ⊠ Neglect ☐ Financial Exploitation. This determination was based on the following: ☐ Abuse The facility had policies and procedures in place to follow a resident's plan of care and the AP was trained to follow the resident's care plan to use a standing lift to transfer the resident. The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for

Compliance:

Minnesota 245C.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under

Facility Name: Presbyterian Homes of Arden Hills

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met. Deficiencies are issued on form 2567: X Yes □ No (The 2567 will be available on the MDH website.) State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met. State licensing orders were issued: x Yes ПNo (State licensing orders will be available on the MDH website.) State Statutes Chapters 144 & 144A - Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 &144A were not met. State licensing orders were issued: X Yes □ No (State licensing orders will be available on the MDH website.) **Compliance Notes: Facility Corrective Action:** The facility took the following corrective action(s): **Definitions:**

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Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the

| Facility Name: Presbyterian Homes of Arden | Report Number: H5424039 |
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| vulnerable adult. | |
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| | |
| Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated | |
| "Substantiated" means a preponderance of the evidence shows that an act that mee maltreatment occurred. | ts the definition of |
| The Investigation included the following: <u>Document Review</u> : The following records were reviewed during the investigation | 1: |
| Medical Records | |
| ☐ Care Guide | |
| ▼ Nurses Notes | |
| Assessments | |
| | |
| ▼ Facility Incident Reports | |
| ▼ Therapy and/or Ancillary Services Records | |
| Other pertinent medical records: | |
| Additional facility records: | |
| | Ambalan Challadh ba dha an dha an chang a dha an am an |
| ▼ Facility Internal Investigation Reports | |
| Personnel Records/Background Check, etc. | |
| 🗵 Facility In-service Records | |
| ▼ Facility Policies and Procedures | |
| Number of additional resident(s) reviewed: Four | |
| Were residents selected based on the allegation(s)? Yes No N/A | |
| Specify: | |
| Were resident(s) identified in the allegation(s) present in the facility at the time of th | e investigation? |
| ○ Yes ● No ○ N/A | |
| Specify: The resident had passed away. | |

Facility Name: Presbyterian Homes of Arden

Time:

4:00 p.m.

Were contacts made with any of the following:

Date:

03/24/2017

Date:

If unable to contact was subpoena issued:

Yes, date subpoena was issued

4/25/2017

☐ Emergency Personnel 🗵 Police Officers ☐ Medical Examiner ☐ Other: Specify

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| T / | The following in | Annione was an | ducted during the | invoctigation | | |
|------------------|-----------------------|-----------------------|-------------------|---------------|-------|---------|
| | th complainant(s) | | | mvestigation. | | <i></i> |
| | contact complaina | nt, attempts were | made on: | | | |
| Date: | Time: | Date: | Time: | Date: | Time: | |
| Interview wi | th family: ① Yes | No | /A Specify: | | | _ |
| Did you inte | rview the resident | (s) identified in all | egation: | | | |
| ○ Yes | No ON/A | Specify: The resid | ent had passed aw | ay. | | |
| Did you inte | rview additional re | esidents? | ○ No | | | |
| Total numbe | er of resident inter | views: Four | | | | |
| Interview wi | th staff: Yes | ○ No ○ N/A | Specify: | | | |
| Tennessen V | Warnings | | | | | |
| Tennessen V | Varning given as re | equired: 💿 Yes | ○ No | | | |
| Total numbe | er of staff interviev | ws: <u>11</u> | | | | |
| Physician Int | erviewed: • Yes | ○ No | | | | |
| Nurse Practi | tioner Interviewed | d: ○Yes • | No | | | |
| Physician As | sistant Interviewe | d: ○Yes • | No | | | |
| Interview wi | th Alleged Perpetr | rator(s): O Yes | No ○ N/A | Specify: | | |
| Attempts to | contact: | | | | | |
| Date: | Time: | Date: | Time: | Date: | Time: | |

Time:

1:30 p.m.

4/28/2017

5/11/2017

10:00 a.m.

○ No

Report Number: H5424039

Observations were conducted related to: Personal Care Nursing Services **X** Call Light Infection Control ▼ Use of Equipment Medication Pass **X** Cleanliness □ Dignity/Privacy Issues Safety Issues **▼** Transfers Facility Tour | Injury Incontinence X Was any involved equipment inspected:

Yes O No N/A O No N/A Was equipment being operated in safe manner: Yes Specify: bathroom where incident occurred Were photographs taken:

Yes O No cc: Health Regulation Division - Licensing & Certification Minnesota Board of Examiners for Nursing Home Administrators Minnesota Board of Nursing The Office of Ombudsman for Long-Term Care Arden Hills Police Department **Arden Hills City Attorney**

Report Number: H5424039

Facility Name: Presbyterian Homes of Arden

Ramsey County Attorney

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PRINTED: 01/24/2018 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCT | | (| | SURVEY PLETED |
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| | | 245424 | B. WING | | | | 10/2 | 20/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | • | | | ESS, CITY, STATE, ZIP CODE | Ī | | |
| PRESBY | TERIAN HOMES OF | ARDEN HILLS | | | HANNA BOULEVARD | | | |
| | | | | ARDEN HILL | S, MN 55112 | | | |
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| {F 000} | INITIAL COMMEN | TS . | {F 0 | 00} | | | | |
| | October 20, 2017, to issued relate to compressive rian Home compliance with 42 requirements for Lot The facility is enroll signature is not required page of the CMS-2 correction is required. | n revisit was conducted on to follow up on deficiencies inplaint H5424039. It is of Arden Hills is in CFR Part 483, subpart B, ong Term Care Facilities. It is ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents. | | | | ****** | | |
| | | | | | | | | |
| LABORATOR | OURFCTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGI | NATURE | | TITLE | | | (X6) DATE |

Electronically Signed

101101001

12/12/2017

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.

PRINTED: 08/04/2017 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | (X3) | (X3) DATE SURVEY COMPLETED | |
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| | | 245424 | B. WING | B. WING | | C 08/04/2017 | |
| | PROVIDER OR SUPPLIER TERIAN HOMES OF | ARDEN HILLS | | STREET ADDRESS, CITY, STATE, ZIP CO 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 | DE . | 00,01,2011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | 1 | HOULD BE | (X5) COMPLETION DATE | |
| F 000 | INITIAL COMMEN | тѕ | FO | 000 | | | |
| F 282 SS=D | to investigate case: As a result, the following for case #H542403 ePOC and therefore the bottom of the first form. Electronic subset as verification 483.21(b)(3)(ii) SEIPERSONS/PER CASE (b)(3) Comprehens The services provious outlined by the compact of the services provious outlined by the case. This REQUIREMENT by: Based on interview failed to ensure the one of four resident required a standing transferred without a bone in his/her known for the services provious outlined to ensure the one of four resident required a standing transferred without a bone in his/her known for the services of the servi | RVICES BY QUALIFIED ARE PLAN sive Care Plans ded or arranged by the facility, comprehensive care plan, qualified persons in ach resident's written plan of NT is not met as evidenced v and record review, the facility e care plan was followed for ts, (R1), reviewed who plift for transfers, when R1 was a standing lift, fell, and broke nee. d was reviewed. R1 diagnoses steoarthritis, osteoporosis, and ad 8/18/2016, indicated R1 e of one staff with a standing | F 2 | 282 | | | |
| ABORATORY | DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGN | IATURE | TITLE | | (X6) DATE | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | (X3) DATE SURVEY COMPLETED | | | | |
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| | | 245424 | B. WING | | | C 08/04/2017 | | | |
| | PROVIDER OR SUPPLIER | | | 3220 | EET ADDRESS, CITY, STATE, ZIP CODE LAKE JOHANNA BOULEVARD DEN HILLS, MN 55112 | | | | |
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| F 282 | R1's brief interview 11/10/2016, with a R1 was cognitively R1's care guide shindicated R1 requiwith a standing lift walk, and was at r R1's nursing progrindicated R1 was the hospital at 4:4 assistance of one transfers. R1's nursing progrindicated R1 fell or during a transfer. The facility occurred 10:30 a.m., indicated R1 fell or during a transfer. The facility falls for indicated R1 was a who took R1's vital injury, completed a about pain. R1 del was lifted from the three staff and plate R1's nursing progrindicated at 5:13 at the right hip, knee | w of mental status dated a score of 14 out of 15 indicated y intact. neet dated 12/30/2016, ired the assistance of one staff for transfers, was unable to isk for falls. ress note dated 2/27/2017, re-admitted to the facility from 5 p.m. R1 required the staff with a standing lift for ress note dated 2/28/2017, in her knees in the bathroom ence report dated 2/28/2017 at ted R1 was being assisted in ursing assistant (NA)-G at the llow up form dated 2/28/2017, assessed after the fall by RN-C, al signs, checked R1's skin for range of motion, and asked R1 nied any pain at the time. R1 efloor with a mechanical lift and | F2 | 282 | | | | | |
| | R1's nursing progr | ress note dated 3/1/2017. | | | | | *** | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | 1 ' ' | TIPLE CONSTRUCTION | COV | (X3) DATE SURVEY COMPLETED | | |
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| | PROVIDER OR SUPPLIER | ARDEN HILLS | | STREET ADDRESS, CITY, STATE, ZIP CO 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 | | , 0-1/L011 | | |
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| F 282 | indicated at 6:32 a. to the effected area R1's nursing progres indicated at 6:41 a. pack interventions of R1's nursing progres indicated at 9:37 a. requested the facility Orders were received. R1's emergency row 3/1/2017, indicated mg for pain and an which revealed a from knee. R1 was not a was given a knee in prescription for oxy R1's nursing progres indicated R1 return p.m. with a knee im to a broken bone. Find facility internal 2/28/2017, indicate registered nurse (R stated nursing assisstanding lift to transform. On 3/20/2017, him/her on 2/28/20 standing lift to help An interview was copractical nurse (LP) | m. R1 received a warm pack (unknown site). ses note dated 3/1/2017, m. R1's medication and warm were ineffective. ses note dated 3/1/2017, m. Family member (FM)-E ty send R1 to the hospital. ed from the nurse practitioner. om progress note dated R1 was given oxycodone 5 x-ray was taken of R1's knee, acture of the tibia of the right candidate for surgery, R1 mmobilizer and additional codone. ses note dated 3/1/2017, ed from the hospital at 7:00 mobilizer on her right leg, due at was given Tramadol 25 mg. investigation document dated d after the fall occurrence iN)-A interviewed R1, who stant (NA)-G did not use the | F 2 | 82 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | | | | |
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| | PROVIDER OR SUPPLIER TERIAN HOMES OF A | ARDEN HILLS | | STREET ADDRESS, CITY, STATE, ZIP COD 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
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| F 282 | witnessed NA-G hot the bathroom with he the waist. LPN-D st transfer belt or the stated she witnessed on her knees. The facility position assistants dated 5/2 assistant is responsionand services to the residents with trans. The nursing assistant choices, follows regulated the residents with trans. The nursing assistant choices, follows regulated the residents with trans. The facility position nurses dated 11/20 nurse will manage the assigned staff under the facility policy for assessment dated will be assessed for requires a standing | on. LPN-D stated she olding on to R1 from behind in his hands holding R1's pants at lated NA-G did not use a standing lift with R1. LPN-D ed R1 fall to the floor landing description for nursing 2016, indicated the nursing sible for the provision of care residents in assisting fers, walking and positioning. Int supports the resident's gulations, and best practices. Int works under the gistered nurse. description for registered 10, indicated the registered the performance of the er his/her supervision. | F 28 | | | | | |
| F 323 SS=G | (d) Accidents. The facility must en (1) The resident env | · | F 32 | 3 | | | | |
| | | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245424 | B. WING | | | C 08/04/2017 | |
| | PROVIDER OR SUPPLIER TERIAN HOMES OF A | ARDEN HILLS | | 3 | TREET ADDRESS, CITY, STATE, ZIP CODE 220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112 | , , , , , , , , , , , , , , , , , , , | 04/2011 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 323 | and assistance dev (n) - Bed Rails. The appropriate alternate bed rail. If a bed or must ensure correct maintenance of bed to the following elem (1) Assess the residence from bed rails prior (2) Review the risks the resident or resident or resident or resident or suppropriate for the rappropriate for | eceives adequate supervision ices to prevent accidents. If facility must attempt to use ives prior to installing a side or side rail is used, the facility it installation, use, and it rails, including but not limited ments. Ident for risk of entrapment ito installation. If and benefits of bed rails with item representative and obtain rior to installation. If the dimensions are resident's size and weight. If is not met as evidenced and record review, the facility use of a standing lift was accident during a transfer for s, (R1), reviewed who lift for transfers, when R1 was a standing lift, fell, and broke | F3 | 323 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 245424 | B. WING | i | | 1 | C (04/2017 |
| | PROVIDER OR SUPPLIER TERIAN HOMES OF A | ARDEN HILLS | | ; | STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 | 1 00/ | 04/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 | R1's brief interview 11/10/2016, with a sR1 was cognitively R1's care guide she indicated R1 require with a standing lift for walk, and was at rise R1's nursing progres indicated R1 was restrained to the hospital at 4:45 assistance of one stransfers. R1's nursing progres indicated R1 fell on during a transfer. The facility occurrent 10:30 a.m., indicated the bathroom by nutime of the fall. The facility falls following indicated R1 was as who took R1's vital injury, completed ra about pain. R1 denit was lifted from the fall three staff and place. | of mental status dated score of 14 out of 15 indicated intact. Deet dated 12/30/2016, ed the assistance of one staff or transfers, was unable to sk for falls. Descriptions as note dated 2/27/2017, e-admitted to the facility from p.m. R1 required the taff with a standing lift for the ses note dated 2/28/2017, her knees in the bathroom the date of the ses sessed after the fall by RN-C, signs, checked R1's skin for the day pain at the time. R1 floor with a mechanical lift and ded into bed. | F3 | 323 | , | | |
| | indicated at 5:13 a.r the right hip, knee, | ess note dated 3/1/2017, m. R1 complained of pain in and heel. Nursing staff 25 milligrams (mg) for pain. | | | | | |
| | | ess note dated 3/1/2017, m. R1 received a warm pack | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | |
|--|--|---|--|-----|---|------------------------------|----------------------------|--|
| | | 245424 | B. WING | | | 1 | 04/2017 | |
| | PROVIDER OR SUPPLIER | ARDEN HILLS | | 3 | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| F 323 | Continued From pa | age 6 | F3 | 323 | | | | |
| | to the effected area | a (unknown site). | | | | | | |
| | R1's nursing progre indicated at 6:41 a. pack interventions | ess note dated 3/1/2017, .m. R1's medication and warm were ineffective. | | | | | | |
| | indicated at 9:37 a requested the facil | ess note dated 3/1/2017, .m. Family member (FM)-E ity send R1 to the hospital. red from the nurse practitioner. | | | | | | |
| | 3/1/2017, indicated mg for pain and an which revealed a fr knee. R1 was not a | om progress note dated I R1 was given oxycodone 5 x-ray was taken of R1's knee, racture of the tibia of the right a candidate for surgery, R1 immobilizer and additional ycodone. | | | | | | |
| | indicated R1 return p.m. with a knee in | ess note dated 3/1/2017, ned from the hospital at 7:00 nmobilizer on her right leg, due R1 was given Tramadol 25 mg. | II TO TO TO THE TOTAL THE TOTAL TO THE TOTAL THE TOTAL TO THE TOTAL TH | | | | | |
| | 2/28/2017, indicate registered nurse (F | investigation document dated after the fall occurrence RN)-A interviewed R1, who stant (NA)-G did not use the after R1. | | | | | | |
| | p.m. on 3/20/2017. him/her on 2/28/20 | onducted with RN-A at 1:25 RN-A stated R1 reported to 17 that NA-G did not use the R1 in the bathroom. | | | | | | |
| | practical nurse (LP 5/11/2017. LPN-D | onducted with licensed N)-D at 3:23 p.m. on stated she went to R1's room ion. LPN-D stated she | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | FIPLE CONSTRUCTION NG | CON | (X3) DATE SURVEY COMPLETED | |
|--|--|---|------------------------|---|-------------------------------|----------------------------|
| | | 245424 | B. WING | | ı | C / 04/2017 |
| | PROVIDER OR SUPPLIER | ARDEN HILLS | | STREET ADDRESS, CITY, STATE, ZIP COD 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 | | 704/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 323 | the bathroom with he the waist. LPN-D st transfer belt or the stated she witnessed on her knees. The facility position assistants dated 5/2 assistant is responsionant services to the residents with transing assistant choices, follows regulated the nursing assistant supervision of a regulated the facility position nurses dated 11/20 nurse will manage that assigned staff under the facility policy for assessment dated will be assessed for requires a standing | elding on to R1 from behind in his hands holding R1's pants at lated NA-G did not use a standing lift with R1. LPN-D and R1 fall to the floor landing description for nursing 2016, indicated the nursing sible for the provision of care residents in assisting and positioning. In the supports the resident's gulations, and best practices and works under the gistered nurse. In description for registered 10, indicated the registered the performance of the er his/her supervision. | F3 | 23 | | |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2017

Ms. Dori Mutch, Administrator Presbyterian Homes of Arden Hills 3220 Lake Johanna Boulevard Arden Hills, MN 55112

Re: Reinspection Results - Complaint Numbers H5424039, H5424041

Dear Ms. Mutch:

On October 20, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on August 8, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kamala Fiske Downing

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

PRINTED: 01/24/2018 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: ___ R-C 10/20/2017 00975 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3220 LAKE JOHANNA BOULEVARD PRESBYTERIAN HOMES OF ARDEN HILLS ARDEN HILLS, MN 55112 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} Initial Comments {2 000} *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10. this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was 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:

Minnesota Department of Health

regulations.

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

The facility is enrolled in ePOC and therefore a

A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5424039. Presbyterian Homes of Arden Hills was found in compliance with state

TITLE

(X6) DATE

Electronically Signed

12/12/17 If continuation sheet 1 of 2

PRINTED: 01/24/2018 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ R-C B. WING 10/20/2017 00975 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3220 LAKE JOHANNA BOULEVARD PRESBYTERIAN HOMES OF ARDEN HILLS ARDEN HILLS, MN 55112 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} {2 000} Continued From page 1 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.

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ С B. WING 00975 08/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD PRESBYTERIAN HOMES OF ARDEN HILLS ARDEN HILLS, MN 55112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was 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:** A complaint investigation was conducted to investigate complaints #H5424039 and #H5424041. As a result, the following correction orders are issued for case #H5424039. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health

Minnesota Department of Health

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

TITLE

(X6) DATE

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00975 08/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD PRESBYTERIAN HOMES OF ARDEN HILLS ARDEN HILLS, MN 55112 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 2 000 Continued From page 1 2 000 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. 2 565 MN Rule 4658.0405 Subp. 3 Comprehensive 2 565 Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the care plan was followed for one of four residents, (R1), reviewed who required a standing lift for transfers, when R1 was transferred without a standing lift, fell, and broke a bone in his/her knee. Findings include: R1's medical record was reviewed. R1 diagnoses

Minnesota Department of Health

low back pain.

included anemia, osteoarthritis, osteoporosis, and

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | A. BOILDING. | | C | | | |
| 00975 | | B. WING | | 08/04/2017 | | | |
| NAME OF | 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 | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE | |
| 2 565 | Continued From pa | ige 2 | 2 565 | | | | |
| | | ed 8/18/2016, indicated R1 e of one staff with a standing | | | | | |
| | R1's brief interview of mental status dated 11/10/2016, with a score of 14 out of 15 indicated R1 was cognitively intact. | | | | | | |
| | indicated R1 requir | eet dated 12/30/2016, ed the assistance of one staff for transfers, was unable to sk for falls. | | | | | |
| | indicated R1 was re the hospital at 4:45 | ess note dated 2/27/2017, e-admitted to the facility from p.m. R1 required the staff with a standing lift for | | | | | |
| | | ess note dated 2/28/2017, her knees in the bathroom | | | | | |
| | 10:30 a.m., indicate | nce report dated 2/28/2017 at ed R1 was being assisted in ursing assistant (NA)-G at the | | | | | |
| | indicated R1 was a who took R1's vital injury, completed ra about pain. R1 den | ow up form dated 2/28/2017, ssessed after the fall by RN-C, signs, checked R1's skin for ange of motion, and asked R1 ied any pain at the time. R1 floor with a mechanical lift and ced into bed. | | · | | | |
| | indicated at 5:13 a. the right hip, knee, | ess note dated 3/1/2017, m. R1 complained of pain in and heel. Nursing staff 25 milligrams (mg) for pain. | | | | | |

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:**

(X3) DATE SURVEY COMPLETED

00975

B. WING

С 08/04/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING: _

DDECDVTEDIAN HOMEC OF ADDEN HILLS

3220 LAKE JOHANNA BOULEVARD

| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
|---------------|--|---------------|---|------------------|
| PRÉFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETE DATE |
| 2 565 | Continued From page 3 | 2 565 | | |
| | R1's nursing progress note dated 3/1/2017, indicated at 6:32 a.m. R1 received a warm pack to the effected area (unknown site). | | | |
| | R1's nursing progress note dated 3/1/2017, indicated at 6:41 a.m. R1's medication and warm pack interventions were ineffective. | | | |
| | R1's nursing progress note dated 3/1/2017, indicated at 9:37 a.m. Family member (FM)-E requested the facility send R1 to the hospital. Orders were received from the nurse practitioner. | | | |
| | R1's emergency room progress note dated 3/1/2017, indicated R1 was given oxycodone 5 mg for pain and an x-ray was taken of R1's knee, which revealed a fracture of the tibia of the right knee. R1 was not a candidate for surgery, R1 was given a knee immobilizer and additional prescription for oxycodone. | | | |
| | R1's nursing progress note dated 3/1/2017, indicated R1 returned from the hospital at 7:00 p.m. with a knee immobilizer on her right leg, due to a broken bone. R1 was given Tramadol 25 mg. | | | |
| | The facility internal investigation document dated 2/28/2017, indicated after the fall occurrence registered nurse (RN)-A interviewed R1, who stated nursing assistant (NA)-G did not use the standing lift to transfer R1. | | | |
| | An interview was conducted with RN-A at 1:25 p.m. on 3/20/2017. RN-A stated R1 reported to him/her on 2/28/2017 that NA-G did not use the standing lift to help R1 in the bathroom. | | | |
| | An interview was conducted with licensed practical nurse (LPN)-D at 3:23 p.m. on epartment of Health | | | |

Minnesota Department of Health

PRINTED: 08/04/2017 **FORM APPROVED** Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00975 08/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD PRESBYTERIAN HOMES OF ARDEN HILLS ARDEN HILLS, MN 55112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) 2 565 Continued From page 4 2 565 5/11/2017. LPN-D stated she went to R1's room to give R1 medication. LPN-D stated she witnessed NA-G holding on to R1 from behind in the bathroom with his hands holding R1's pants at the waist. LPN-D stated NA-G did not use a transfer belt or the standing lift with R1. LPN-D stated she witnessed R1 fall to the floor landing on her knees. The facility position description for nursing assistants dated 5/2016, indicated the nursing assistant is responsible for the provision of care and services to the residents in assisting residents with transfers, walking and positioning. The nursing assistant supports the resident's choices, follows regulations, and best practices. The nursing assistant works under the supervision of a registered nurse. The facility position description for registered nurses dated 11/2010, indicated the registered nurse will manage the performance of the assigned staff under his/her supervision. The facility policy for resident transfer assessment dated 2/2016, indicated all residents will be assessed for transfer needs. If a resident requires a standing lift it will be documented in the care plan and the nursing assistant care sheet.

Minnesota Department of Health

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and

monitor to ensure compliance.

Twenty-One (21) days.

TIME PERIOD FOR CORRECTION:

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|------------------------|---|--|----------------------------|--|------------------|------------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | | |
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| | 00975 | | B. WING | | | 4/2017 | |
| NAME OF (| DOVIDED OD SUDDIJED | CTDEET AD | | OTATE ZID CODE | | | |
| NAME OF E | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD | | | | | | |
| PRESBY | TERIAN HOMES OF | ARDEN HILLS | ILLS, MN 55 | | | | |
| (V4) ID | SIIMMADV STA | TEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTI | ON | (VE) | |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETE | |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE | |
| | | Manage and | | DEI IOIENOT) | | | |
| 21850 | Continued From pa | ige 5 | 21850 | | | | |
| 21050 | MNI Ct. Ctatuta 144 | .651 Subd. 14 Patients & | 21850 | | | | |
| 21000 | Residents of HC Fa | | 21000 | | | | |
| | 11001001110 01 110 1 | ao.biii or riiginto | | | | | |
| | | om from maltreatment. | | | | | |
| | | free from maltreatment as | | | | | |
| | | erable Adults Protection Act. ans conduct described in | | | | | |
| | | subdivision 15, or the | | | | | |
| | | -therapeutic infliction of | | | | | |
| | | ury, or any persistent course of | | | | | |
| | | produce mental or emotional | | | | | |
| | | ident shall also be free from | | | | | |
| | | emical and physical restraints, mented emergencies, or as | | | | | |
| | | g after examination by a | | | | | |
| | resident's physiciar | for a specified and limited | | | | | |
| | | only when necessary to | | | | | |
| | | t from self-injury or injury to | | | | | |
| | others. | | | | | | |
| | This MN Requirem | ent is not met as evidenced | | | | | |
| | by: | | | | | | |
| | | and record review, the facility | | | | | |
| | | esident was free from | | | | | |
| | | ne of four residents, (R1), | | | | | |
| | reviewed who required a standing lift for transfers, when R1 was transferred without a | | | | | | |
| | | nd broke a bone in his/her | | | | | |
| | knee. | | | | | | |
| | | | | | | | |
| | Findings include: | | | | | | |
| | The facility policy ti | tled "Understanding | | | | | |
| | | Inerable Adults" (undated) | | | | | |
| | indicated failing to t | follow a resident's plan of care | | | | | |
| | is considered neglect and could result in termination of employment. NA-G signed the | | | | | | |
| | | | | · | | | |
| | document 12/2/201 | o. | | | | | |
| | | | | | | | |

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | DATE SURVEY COMPLETED | |
|---|--|---|--------------------------|--|--------|--------------------------|--|
| | | | A. BUILDING: | | C | | |
| 00975 | | B. WING | | | 4/2017 | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| PRESBY | TERIAN HOMES OF | ARDEN HILLS | E JOHANNA ILLS, MN 55 | BOULEVARD 1112 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE | |
| 21850 | Continued From pa | ige 6 | 21850 | | | | |
| | nurses dated 11/20 nurse will manage assigned staff unde | description for registered 10, indicated the registered the performance of the er his/her supervision. | | | | | |
| | will be assessed fo requires a standing | or resident transfer 2/2016, indicated all residents r transfer needs. If a resident lift it will be documented in the nursing assistant care | | | | | |
| | assistants dated 5/s assistant is respons and services to the residents with trans The nursing assista choices, follows reg | description for nursing 2016, indicated the nursing sible for the provision of care residents in assisting sfers, walking and positioning. ant supports the resident's gulations, and best practices. ant works under the gistered nurse. | | | | | |
| | | d was reviewed. R1 diagnoses steoarthritis, osteoporosis, and | | | | | |
| | | ed 8/18/2016, indicated R1 e of one staff with a standing | | | | | |
| | | of mental status dated score of 14 out of 15 indicated intact. | | | | | |
| | indicated R1 requir | eet dated 12/30/2016, ed the assistance of one staff for transfers, was unable to sk for falls. | | | | | |
| | R1's nursing progre | ess note dated 2/27/2017, | | | | | |

Minnesota Department of Health

Minnesota Department of Health

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | |
|---|--|--|---------------------|---|-----------------|--|--|
| | 00975 | | B. WING | | C 08/04/2017 | | |
| | NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF ARDEN HILLS STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112 | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETE | | |
| 21850 | the hospital at 4:45 assistance of one stransfers. R1's nursing progresindicated R1 fell on during a transfer. The facility occurred 10:30 a.m., indicated the bathroom by nuttime of the fall. The facility falls folk indicated R1 was as who took R1's vital injury, completed ra about pain. R1 deni was lifted from the staff and place R1's nursing progresindicated at 5:13 a. Ithe right hip, knee, provided Tramadol R1's nursing progresindicated at 6:32 a. Ito the effected area R1's nursing progresindicated at 6:41 a. It pack interventions with the staff and progresindicated at 9:37 a. It's nursing progres | e-admitted to the facility from p.m. R1 required the taff with a standing lift for ess note dated 2/28/2017, her knees in the bathroom ence report dated 2/28/2017 at ed R1 was being assisted in rsing assistant (NA)-G at the ence of motion, and asked R1 ed any pain at the time. R1 floor with a mechanical lift and ed into bed. ess note dated 3/1/2017, enc. R1 complained of pain in and heel. Nursing staff 25 milligrams (mg) for pain. ess note dated 3/1/2017, enc. R1 received a warm pack (unknown site). ess note dated 3/1/2017, enc. R1's medication and warm were ineffective. | 21850 | | | | |
| | | ty send R1 to the hospital. ed from the nurse practitioner. | | | | | |

Minnesota Department of Health STATE FORM

PRINTED: 08/04/2017 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00975 08/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD PRESBYTERIAN HOMES OF ARDEN HILLS ARDEN HILLS, MN 55112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID חו (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21850 Continued From page 8 21850 R1's emergency room progress note dated 3/1/2017, indicated R1 was given oxycodone 5 mg for pain and an x-ray was taken of R1's knee, which revealed a fracture of the tibia of the right knee. R1 was not a candidate for surgery, R1 was given a knee immobilizer and additional prescription for oxycodone. R1's nursing progress note dated 3/1/2017, indicated R1 returned from the hospital at 7:00 p.m. with a knee immobilizer on her right leg, due to a broken bone. R1 was given Tramadol 25 mg. The facility internal investigation document dated 2/28/2017, indicated after the fall occurrence registered nurse (RN)-A interviewed R1, who stated nursing assistant (NA)-G did not use the standing lift to transfer R1. An interview was conducted with RN-A at 1:25 p.m. on 3/20/2017. RN-A stated R1 reported to him/her on 2/28/2017 that NA-G did not use the standing lift to help R1 in the bathroom. An interview was conducted with licensed practical nurse (LPN)-D at 3:23 p.m. on 5/11/2017. LPN-D stated she went to R1's room to give R1 medication. LPN-D stated she witnessed NA-G holding on to R1 from behind in the bathroom with his hands holding R1's pants at the waist, LPN-D stated NA-G did not use a

Minnesota Department of Health

on her knees.

transfer belt or the standing lift with R1. LPN-D stated she witnessed R1 fall to the floor landing

residents with transfers, walking and positioning.

The facility position description for nursing assistants dated 5/2016, indicated the nursing assistant is responsible for the provision of care and services to the residents in assisting

PRINTED: 08/04/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ С B. WING 00975 08/04/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 LAKE JOHANNA BOULEVARD PRESBYTERIAN HOMES OF ARDEN HILLS ARDEN HILLS, MN 55112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21850 Continued From page 9 21850 The nursing assistant supports the resident's choices, follows regulations, and best practices. The nursing assistant works under the supervision of a registered nurse. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.

Minnesota Department of Health