DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 23, 2021

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

RE: CCN: 245424
Cycle Start Date: June 3, 2021

Dear Administrator:

On July 20, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
June 21, 2021

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

RE: CCN: 245424
Cycle Start Date: June 3, 2021

Dear Administrator:

On June 3, 2021, 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" tag), i.e., the plan of correction should be directed to:

Jamie Perell, 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: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 3, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 3, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	C 06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/2/21, through 6/3/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5424078C (MN00070235), with deficiencies cited at F677 and F686. The following complaint were found to be SUBSTANTIATED: H5424077C (MN00062333), however, no deficiencies were cited due to corrective actions taken by the facility: The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 677	This Plan of Correction and the	7/16/21

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

Electronically Signed | 06/29/2021

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F 677	Continued From page 1 review, the facility failed to implement timely incontinence care, as directed by the care plan, for 1 of 3 residents (R3) who was always incontinent of bowel and bladder. Findings include: R3's Face Sheet dated 6/3/21, indicated diagnoses of dementia without behavioral disturbances and heart failure. R3's quarterly Minimum Data Set (MDS) dated 4/21/21, indicated R1 had severe cognitive impairment, and required extensive assistance for toileting. R1 was always incontinent of bowl and bladder. R3's bowl and bladder care area assessment (CAA) dated 1/26/21, indicated R1 was incontinent of bowl and bladder. The CAA further indicated R3 required staff assistance due to weakness and inability to stand or walk. R3's care plan dated 5/5/21, indicated R3 had functional bladder/bowel incontinence and required assistance of two staff to check and change their incontinence product every three hours and as needed. R3's care plan further indicated if R3 refused to be checked or changed, staff were to reapproach R3. Review of R3's progress notes dated 4/1/21, through 6/3/21, lacked indication documentation R3 refused cares. On 6/2/21, at 10:24 a.m. a continuous observation was conducted from 10:24 a.m. to 2:01 p.m. At 10:24 a.m. R3 was seated in a wheelchair watching television in their room with	F 677	responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. R3 was provided assistance with incontinence care upon identification. R3 has had a Bowel, Bladder and Skin Risk assessment completed on 4/23/2021 to ensure that she has been comprehensively assessed and that her plan of care and care sheets match the individualized needs identified on this assessment. NAR caring for R3 was provided education and coaching related to not following plan of care and proper process for refusal of care. A full house audit is being completed for all current residents, including review of care plan, care sheet, and assessments to ensure ongoing compliance and safety regarding ADLs for dependent residents. The facility has reviewed the policy titled Toileting Residents and it remains appropriate. All nursing staff are receiving education on the process to ensure the plan of care is being followed using the care sheets and shift report. In addition, staff will be educated on refusals and	

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F 677	Continued From page 2 the door open. At 12:05 a.m., nursing assistant (NA)-A entered R3's room and asked R3 if she was ready for lunch. NA-A then brought R3 to the dining room without offering to check for incontinence. At 12:12 p.m. R3 remained in her wheelchair and was eating lunch in dining room. At 12:41 p.m. R3 remained seated in the wheelchair in dining room and was visiting with staff and residents. Toileting was not offered. At 12:55 p.m. R3 remained seated in the wheelchair in dining room and was talking with the Chaplain. At 12:58 p.m. R3 was wheeled back to her room and continued to watch television while seated in the wheelchair. R3 was not offered toileting. At 2:01p.m., after surveyor inquiry regarding incontinence cares, NA-A entered R3's room and offered to help R3 return to bed and provide incontinence cares. R3 stated she did not want to be changed and was concentrating on the television show. R3 had not been offered incontinent cares for three hours and 37 minutes. At 3:27 p.m., R3 was reapproached by NA-B and LPN-B. NA-B and LPN-B assisted R3 back to bed. R3 was lifted into bed with a hoyer lift and R3's clothing and lift sling was noted to be soiled with urine and stool. LPN-B measured the redness on R3's buttocks to be nine centimeters (cm) by four cm and verified the red area was blanchable. R3 was changed and perineal cares performed. Prior to 3:27 p.m. no attempts to reapproach R37 were observed. When interviewed on 6/2/21, at 1:54 p.m. NA-A stated R3 had been in her wheelchair since about 8:00 a.m. NA-A stated R3 was offered to get back to bed and be changed around 10:45 a.m., but R3 refused. NA-A confirmed when R3 refused care at about 10:45 a.m., LPN-A was not notified and R3 was not reapproached as it was time for	F 677	reapproach in regard to activities of daily living (ADLs). 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. 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 Friday, July 16, 2021.	

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F 677	Continued From page 3	F 677		

her break. NA-A stated R3 refused cares and was sometimes confused and combatitive. NA-A stated when R3 refused cares, LPN-A needed to be notified and R3 should be reapproached. NA-A further stated upon return from break, it was lunchtime and R3 was brought to the dining room. NA-A verified R3 was to have incontinent cares every three. Contrary to the above statement, upon continuous observation, no attempts to toilet R3 were observed.

When interviewed on 6/2/21 at 2:07 p.m., LPN-A stated R3 needed to be changed every three hours and required two staff to perform incontinence cares. LPN-A stated he was unaware R3 had refused cares. LPN-A stated he was not aware how long R3 was in her chair until NA-A reported the information a few minutes ago. LPN-A stated when R3 refused cares, staff documented refusals in progress notes and the information was also passed on to the next shift.

When interviewed on 6/2/21, at 2:21 p.m., NA-B stated R3 was incontinent and could resist when attempting cares. NA-B stated when R3 refused cares, staff needed to reapproach and keep trying. NA-B stated a nurse should be notified when R3 refused. NA-B stated R3 was not able to reposition herself in her wheelchair and required assistance of two to move. NA-B stated R3's refusal of care needed to be documented on a task sheet in the electronic medical record (EMR).

When interviewed on 6/2/21, at 3:21 p.m. registered nurse (RN)-A stated it was expected for NAs' to follow the care plan for the residents. RN-A stated when a resident refused care, the NA staff needed to reapproach. RN-A stated the

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F 677	Continued From page 4 reapproach should happen within the hour and if care was still refused, the nurse must be notified. RN-A stated the nurse should also approach the resident. RN-A stated both nurses and NA's need to document in the EMR when a resident refused care. When interviewed on 6/2/21, at 4:00 p.m. LPN-B stated R3 needed incontinence care and it was to be performed every two to three hours. LPN-B stated when R3 refused care, staff needed to reapproach a resident until the cares were completed. LPN-B stated if reapproaching was not successful a progress note was needed. When interviewed on 6/3/21, at 12:35 p.m., director of nursing (DON) stated the expectation was for staff to follow a resident's care plan. The DON stated if a resident refused care, the resident was to be reassessed, or reapproached within 30 to 60 minutes. The facility's policy Toileting Residents dated 12/2014, indicated the level of dependence and time frame's of the resident's toileting will be identified on the care plan. and nursing will monitor for compliance each shift.	F 677		
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		7/16/21

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F 686	Continued From page 5 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 implement pressure ulcer interventions of turning and repositioning for 1 of 3 residents (R3) identified at risk for pressure ulcers. Findings include: R3's Face Sheet dated 6/3/21, indicated diagnoses of dementia without behavioral disturbances and heart failure. R3's quarterly Minimum Data Set (MDS) dated 4/21/21, indicated R1 had a severe cognitive impairment, required extensive assistance of two staff for bed mobility, and was totally dependent on two staff for transfers. R3 was noted to have a stage one pressure injury. R3's pressure injury Care Area Assessment (CAA) dated 1/26/21, indicated R3 was at risk for pressure ulcers due to incontinence of bowl and bladder. R3 required assistance of two staff for bed mobility. R3 was not able to stand or walk. R3's Bowl, Bladder and Skin Risk Summary dated 4/23/21, indicated R3 was at moderate risk for skin breakdown. R1 was to be repositioned every three hours during the day and every four hours during the night.	F 686	R3 was provided assistance with immediate care upon identification. R3 has had a Bowel, Bladder and Skin Risk assessment completed on 4/23/2021 to ensure that she has been comprehensively assessed and that her plan of care and care sheets match the individualized needs identified on this assessment. NAR caring for R3 was provided education and coaching related to not following plan of care, proper process for refusal of care and potential negative outcomes related to these actions. Facility continues to monitor the skin of R3 through weekly body audits with no new findings. A full house audit is being completed for all current residents, including review of care plan, care sheet, and assessments to ensure ongoing compliance and safety regarding pressure injury prevention and care. The facility has reviewed the Skin Management Policy and it remains in effect. All nursing staff are receiving education on the process to ensure the plan of care is being followed using the care sheets and shift report. In addition, staff will be educated on refusals and reapproach in regard to activities of daily living (ADLs).	

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F 686	Continued From page 6 R3's care plan dated 5/5/21, indicated R3 was not able to ambulate, required assistance of two staff for repositioning, and was at risk for developing pressure injuries. The care plan further indicated R3 was to be repositioned every three hours and as needed. If R3's refused cares, staff were to return and reapproach R3. R3's progress notes reviewed from 4/1/21, through 6/1/21, lacked indication R3 refused repositioning. On 6/2/21, a continuous observation from at 10:24 a.m. to 2:01 p.m. At 10:24 a.m. R3 was observed sitting in a wheelchair watching television in their room. At 12:05 a.m. nursing assistant (NA)-A entered R3's room and asked R3 if she was ready for lunch. NA-A then wheeled R3 to the dining room and was not offered repositioning at this time. At 12:12 p.m. R3 was seated in her wheelchair eating lunch in the dining room. At 12:41 p.m., R3 remained seated in the wheelchair in dining room and visited with staff and other resident. R3 was not offered repositioning. At 12:55 p.m. R3 remained seated in her wheelchair in the dining room and spoke to a Chaplin. At 12:58 p.m. R3 was wheeled back to their room and was not offered repositioning at this time. R3 continued to watch television while seated in the wheelchair. At 2:01p.m. NA-A entered R3's room and asked R3 to return to bed and to change R3's incontinent pad. R3 told NA-A she did not want to go to bed, or be changed, and she was concentrating on a television show. R3 was not offered repositioning for three hours and 37 minutes. At 3:27 p.m. R3 was reapproached by NA-B and LPN-B. NA-B and LPN-B assisted R3 back to bed. R3 was lifted into bed with a hoyer lift and R3's clothing and lift sling was noted	F 686	The facility will complete random audits of 10% of residents weekly to ensure ongoing compliance with provision of care to prevent pressure injury development as directed by the care sheet/care plan. In addition, the facility will audit 10% of all residents with skin issues to ensure ongoing provision of care as directed by their individualized plan of care. 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 Tuesday, July 16, 2021.	

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F 686	Continued From page 7	F 686		

to be incontinent of urine and stool. R3's buttocks was varying shades of red which extended down to the top of their legs. LPN-B measured the redness on R3's buttocks to be nine centimeters (cm) by four cm and verified the red area was blanchable. Prior to 3:27 p.m. staff made no attempts to reapproach R37, to offer repositioning.

When interviewed on 6/2/21, at 1:54 p.m. NA-A stated R3 had been in her wheelchair since about 8:00 a.m. NA-A stated R3 was offered to get back to bed and be changed around 10:45 a.m., but R3 refused. NA-A confirmed when R3 refused care at about 10:45 a.m., LPN-A was not notified and R3 was not reapproached as it was time for her break. NA-A stated R3 refused cares and was sometimes confused and combative. NA-A stated when R3 refused cares, LPN-A needed to be notified and R3 should be reapproached. NA-A further stated upon return from break, it was lunchtime and R3 was brought to the dining room. NA-A verified R3 was to be repositioned every three hours. Contrary to the above statement, upon continuous observation, no attempts to reposition R3 were observed from 10:24 a.m until 2:01 p.m.

When interviewed on 6/2/21 at 2:07 p.m., LPN-A stated R3 had to be repositioned every three hours. LPN-A stated he was not notified R3 had refused repositioning. LPN-A stated he was not aware how long R3 was in their wheelchair until NA-A informed him just now. LPN-A stated when R3 refused care, staff needed reapproach after a few minutes. LPN-A stated if R3 continued to refuse, the charge nurse needed to be notified. LPN-A also stated if a resident refused cares this was to be documented in a progress notes and

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(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 communicated to the next shift. When interviewed on 6/2/21, at 2:21 p.m. NA-B stated R3 was resistive to cares, at times. NA-B stated if R3 refused, staff needed to reapproach. NA-B stated, at times, R3 was agreeable with a different person. NA-B stated a nurse needed to be notified when R3 refused cares. NA-B stated R3 was not able to reposition herself in a wheelchair and required assistance of two staff. NA-B stated R3's refusal of care needed to be documented on the task sheet in the electronic medical record (EMR). When interviewed on 6/2/21, at 3:21 p.m. registered nurse (RN)-A stated it was expected for NAs' to follow the care plan for the residents. RN-A stated when a resident refused care, the NA staff needed to reapproach. RN-A stated the reapproach should happen within the hour and if care was still refused, the nurse must be notified. RN-A stated the nurse should also approach the resident. RN-A stated both nurses and NA's need to document in the EMR when a resident refused care. When interviewed on 6/2/21, at 4:00 p.m. LPN-B stated R3 needed to be repositioned every two to three hours. LPN-B stated when R3 refused care, staff needed to reapproach a resident until the cares were completed. LPN-B stated if reapproaching was not successful a progress note was needed. When interviewed on 6/3/21, at 12:35 p.m. director of nursing (DON) stated staff were expected to follow the resident's care plan. The DON stated if a resident refused care, staff must reassess or reapproach within 30 to 60 minutes	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	C 06/03/2021

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F 686	Continued From page 9 and follow-up with a nurse. The DON stated NAs' document refusals in their task sheets and nurses document refused care in a progress notes.	F 686		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 21, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 7RTJ11

Dear Administrator:

The above facility was surveyed on June 2, 2021 through June 3, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jamie Perell, 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: jamie.perell@state.mn.us
Office: (651) 245-8094

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

Please 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	00975	A. BUILDING: _____ B. WING _____	C 06/03/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/2/21, through 6/3/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5424078C (MN70253) with a licensing orders issued at 0840, 0905 and 0920.. The following complaint was found to be SUBSTANTIATED: H5424077C (MN62333), however, no licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in	2 840		7/16/21

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2 840	Continued From page 3 determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement timely incontinence care, as directed by the care plan, for 1 of 3 residents (R3) who was always incontinent of bowel and bladder. Findings include: R3's Face Sheet dated 6/3/21, indicated diagnoses of dementia without behavioral disturbances and heart failure. R3's quarterly Minimum Data Set (MDS) dated 4/21/21, indicated R1 had severe cognitive impairment, and required extensive assistance for toileting. R1 was always incontinent of bowl and bladder. R3's bowl and bladder care area assessment (CAA) dated 1/26/21, indicated R1 was	2 840	Corrected	

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2 840	Continued From page 4 incontinent of bowl and bladder. The CAA further indicated R3 required staff assistance due to weakness and inability to stand or walk. R3's care plan dated 5/5/21, indicated R3 had functional bladder/bowel incontinence and required assistance of two staff to check and change their incontinence product every three hours and as needed. R3's care plan further indicated if R3 refused to be checked or changed, staff were to reapproach R3. Review of R3's progress notes dated 4/1/21, through 6/3/21, lacked indication documentation R3 refused cares. On 6/2/21, at 10:24 a.m. a continuous observation was conducted from 10:24 a.m. to 2:01 p.m. At 10:24 a.m. R3 was seated in a wheelchair watching television in their room with the door open. At 12:05 a.m., nursing assistant (NA)-A entered R3's room and asked R3 if she was ready for lunch. NA-A then brought R3 to the dining room without offering to check for incontinence. At 12:12 p.m. R3 remained in her wheelchair and was eating lunch in dining room. At 12:41 p.m. R3 remained seated in the wheelchair in dining room and was visiting with staff and residents. Toileting was not offered. At 12:55 p.m. R3 remained seated in the wheelchair in dining room and was talking with the Chaplain. At 12:58 p.m. R3 was wheeled back to her room and continued to watch television while seated in the wheelchair. R3 was not offered toileting. At 2:01p.m., after surveyor inquiry regarding incontinence cares, NA-A entered R3's room and offered to help R3 return to bed and provide incontinence cares. R3 stated she did not want to be changed and was concentrating on the television show. R3 had not been offered	2 840		

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2 840	Continued From page 5	2 840		

incontinent cares for three hours and 37 minutes. At 3:27 p.m., R3 was reapproached by NA-B and LPN-B. NA-B and LPN-B assisted R3 back to bed. R3 was lifted into bed with a hoyer lift and R3's clothing and lift sling was noted to be soiled with urine and stool. LPN-B measured the redness on R3's buttocks to be nine centimeters (cm) by four cm and verified the red area was blanchable. R3 was changed and perineal cares performed. Prior to 3:27 p.m. no attempts to reapproach R37 were observed.

When interviewed on 6/2/21, at 1:54 p.m. NA-A stated R3 had been in her wheelchair since about 8:00 a.m. NA-A stated R3 was offered to get back to bed and be changed around 10:45 a.m., but R3 refused. NA-A confirmed when R3 refused care at about 10:45 a.m., LPN-A was not notified and R3 was not reapproached as it was time for her break. NA-A stated R3 refused cares and was sometimes confused and combatitive. NA-A stated when R3 refused cares, LPN-A needed to be notified and R3 should be reapproached. NA-A further stated upon return from break, it was lunchtime and R3 was brought to the dining room. NA-A verified R3 was to have incontinent cares every three. Contrary to the above statement, upon continuous observation, no attempts to toilet R3 were observed.

When interviewed on 6/2/21 at 2:07 p.m., LPN-A stated R3 needed to be changed every three hours and required two staff to perform incontinence cares. LPN-A stated he was unaware R3 had refused cares. LPN-A stated he was not aware how long R3 was in her chair until NA-A reported the information a few minutes ago. LPN-A stated when R3 refused cares, staff documented refusals in progress notes and the information was also passed on to the next shift.

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2 840	Continued From page 6 When interviewed on 6/2/21, at 2:21 p.m., NA-B stated R3 was incontinent and could resist when attempting cares. NA-B stated when R3 refused cares, staff needed to reapproach and keep trying. NA-B stated a nurse should be notified when R3 refused. NA-B stated R3 was not able to reposition herself in her wheelchair and required assistance of two to move. NA-B stated R3's refusal of care needed to be documented on a task sheet in the electronic medical record (EMR). When interviewed on 6/2/21, at 3:21 p.m. registered nurse (RN)-A stated it was expected for NAs' to follow the care plan for the residents. RN-A stated when a resident refused care, the NA staff needed to reapproach. RN-A stated the reapproach should happen within the hour and if care was still refused, the nurse must be notified. RN-A stated the nurse should also approach the resident. RN-A stated both nurses and NA's need to document in the EMR when a resident refused care. When interviewed on 6/2/21, at 4:00 p.m. LPN-B stated R3 needed incontinence care and it was to be performed every two to three hours. LPN-B stated when R3 refused care, staff needed to reapproach a resident until the cares were completed. LPN-B stated if reapproaching was not successful a progress note was needed. When interviewed on 6/3/21, at 12:35 p.m., director of nursing (DON) stated the expectation was for staff to follow a resident's care plan. The DON stated if a resident refused care, the resident was to be reassessed, or reapproached within 30 to 60 minutes.	2 840		

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2 840	Continued From page 7 The facility's policy Toileting Residents dated 12/2014, indicated the level of dependence and time frame's of the resident's toileting will be identified on the care plan. and nursing will monitor for compliance each shift. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure residents are offered toileting and processes related to reapproaching if a resident refuses. The DON, or designee, could educate all staff on the policies and procedures. The DON, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement pressure ulcer interventions of turning and repositioning for 1 of 3 residents (R3) identified at risk for pressure	2 905	Corrected	7/16/21

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2 905	Continued From page 8 ulcers. Findings include: R3's Face Sheet dated 6/3/21, indicated diagnoses of dementia without behavioral disturbances and heart failure. R3's quarterly Minimum Data Set (MDS) dated 4/21/21, indicated R1 had a severe cognitive impairment, required extensive assistance of two staff for bed mobility, and was totally dependent on two staff for transfers. R3 was noted to have a stage one pressure injury. R3's pressure injury Care Area Assessment (CAA) dated 1/26/21, indicated R3 was at risk for pressure ulcers due to incontinence of bowl and bladder. R3 required assistance of two staff for bed mobility. R3 was not able to stand or walk. R3's Bowl, Bladder and Skin Risk Summary dated 4/23/21, indicated R3 was at moderate risk for skin breakdown. R1 was to be repositioned every three hours during the day and every four hours during the night. R3's care plan dated 5/5/21, indicated R3 was not able to ambulate, required assistance of two staff for repositioning, and was at risk for developing pressure injuries. The care plan further indicated R3 was to be repositioned every three hours and as needed. If R3's refused cares, staff were to return and reapproach R3. R3's progress notes reviewed from 4/1/21, through 6/1/21, lacked indication R3 refused repositioning. On 6/2/21, a continuous observation from at	2 905		

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2 905	Continued From page 9	2 905		

10:24 a.m. to 2:01 p.m. At 10:24 a.m. R3 was observed sitting in a wheelchair watching television in their room. At 12:05 a.m. nursing assistant (NA)-A entered R3's room and asked R3 if she was ready for lunch. NA-A then wheeled R3 to the dining room and was not offered repositioning at this time. At 12:12 p.m. R3 was seated in her wheelchair eating lunch in the dining room. At 12:41 p.m., R3 remained seated in the wheelchair in dining room and visited with staff and other resident. R3 was not offered repositioning. At 12:55 p.m. R3 remained seated in her wheelchair in the dining room and spoke to a Chaplin. At 12:58 p.m. R3 was wheeled back to their room and was not offered repositioning at this time. R3 continued to watch television while seated in the wheelchair. At 2:01p.m. NA-A entered R3's room and asked R3 to return to bed and to change R3's incontinent pad. R3 told NA-A she did not want to go to bed, or be changed, and she was concentrating on a television show. R3 was not offered repositioning for three hours and 37 minutes. At 3:27 p.m. R3 was reapproached by NA-B and LPN-B. NA-B and LPN-B assisted R3 back to bed. R3 was lifted into bed with a hoyer lift and R3's clothing and lift sling was noted to be incontinent of urine and stool. R3's buttocks was varying shades of red which extended down to the top of their legs. LPN-B measured the redness on R3's buttocks to be nine centimeters (cm) by four cm and verified the red area was blanchable. Prior to 3:27 p.m. staff made no attempts to reapproach R37, to offer repositioning.

When interviewed on 6/2/21, at 1:54 p.m. NA-A stated R3 had been in her wheelchair since about 8:00 a.m. NA-A stated R3 was offered to get back to bed and be changed around 10:45 a.m., but R3 refused. NA-A confirmed when R3 refused

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00975	A. BUILDING: _____ B. WING _____	C 06/03/2021

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

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2 905	Continued From page 10	2 905		

care at about 10:45 a.m., LPN-A was not notified and R3 was not reapproached as it was time for her break. NA-A stated R3 refused cares and was sometimes confused and combative. NA-A stated when R3 refused cares, LPN-A needed to be notified and R3 should be reapproached. NA-A further stated upon return from break, it was lunchtime and R3 was brought to the dining room. NA-A verified R3 was to be repositioned every three hours. Contrary to the above statement, upon continuous observation, no attempts to reposition R3 were observed from 10:24 a.m until 2:01 p.m.

When interviewed on 6/2/21 at 2:07 p.m., LPN-A stated R3 had to be repositioned every three hours. LPN-A stated he was not notified R3 had refused repositioning. LPN-A stated he was not aware how long R3 was in their wheelchair until NA-A informed him just now. LPN-A stated when R3 refused care, staff needed reapproach after a few minutes. LPN-A stated if R3 continued to refuse, the charge nurse needed to be notified. LPN-A also stated if a resident refused cares this was to be documented in a progress notes and communicated to the next shift.

When interviewed on 6/2/21, at 2:21 p.m. NA-B stated R3 was resistive to cares, at times. NA-B stated if R3 refused, staff needed to reapproach. NA-B stated, at times, R3 was agreeable with a different person. NA-B stated a nurse needed to be notified when R3 refused cares. NA-B stated R3 was not able to reposition herself in a wheelchair and required assistance of two staff. NA-B stated R3's refusal of care needed to be documented on the task sheet in the electronic medical record (EMR).

When interviewed on 6/2/21, at 3:21 p.m.

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2 905	Continued From page 11 registered nurse (RN)-A stated it was expected for NAs' to follow the care plan for the residents. RN-A stated when a resident refused care, the NA staff needed to reapproach. RN-A stated the reapproach should happen within the hour and if care was still refused, the nurse must be notified. RN-A stated the nurse should also approach the resident. RN-A stated both nurses and NA's need to document in the EMR when a resident refused care. When interviewed on 6/2/21, at 4:00 p.m. LPN-B stated R3 needed to be repositioned every two to three hours. LPN-B stated when R3 refused care, staff needed to reapproach a resident until the cares were completed. LPN-B stated if reapproaching was not successful a progress note was needed. When interviewed on 6/3/21, at 12:35 p.m. director of nursing (DON) stated staff were expected to follow the resident's care plan. The DON stated if a resident refused care, staff must reassess or reapproach within 30 to 60 minutes and follow-up with a nurse. The DON stated NAs' document refusals in their task sheets and nurses document refused care in a progress notes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures related to positioning. The DON, or designee, could train staff and conduct audits to ensure care plans are being followed. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 905		