

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.

M. Ping

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



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: 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:

Presbyterian Homes Of Arden Hills June 21, 2021 Page 2

- 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).

Presbyterian Homes Of Arden Hills June 21, 2021 Page 3

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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,

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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

						-	APPROVED
		& MEDICAID SERVICES				1	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY IPLETED
		245424	B. WING				C 03/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
DDECDV				32	220 LAKE JOHANNA BOULEVARD		
PRESDI	TERIAN HOMES OF A	ARDEN HILLS		Α	RDEN HILLS, MN 55112		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	FC	000			
	abbreviated survey Your facility was fou with the requirement	6/3/21, a standard was conducted at your facility. Ind to be NOT in compliance hts of 42 CFR 483, Subpart B, ong Term Care Facilities.					
	SUBSTANTIATED:	laints were found to be H5424078C (MN00070235), ed at F677 and F686.					
	SUBSTANTIATED:	laint were found to be H5424077C (MN00062333), ncies were cited due to aken by the facility:					
	as your allegation o Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the stance. Because you are rour signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.					
F 677 SS=D	onsite revisit of you validate that substa regulations has bee ADL Care Provided	for Dependent Residents	F6	577			7/16/21
	out activities of daily services to maintair personal and oral h This REQUIREMEN by:	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview, and document			This Plan of Correction and the		
LABORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE
Electron	ically Signed						06/29/2021

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.

DEDADTMENT OF LIEALTH AND LIUMANN CEDVICES

PRINTED: 06/30/2021

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		0938-039 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
			A. BOILDIN	۵ <u></u>		С
		245424	B. WING			03/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
PRESBY	TERIAN HOMES OF	ARDEN HILLS		3220 LAKE JOHANNA BOULEVAF ARDEN HILLS, MN 55112	RD	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 677	Continued From pa	age 1	F 67	7		
F 6//	review, the facility f incontinence care, for 1 of 3 residents incontinent of bowe Findings include: R3's Face Sheet da diagnoses of deme disturbances and h R3's quarterly Minit 4/21/21, indicated I impairment, and re for toileting. R1 was and bladder. R3's bowl and blad (CAA) dated 1/26/2 incontinent of bowl indicated R3 requir weakness and inab R3's care plan date functional bladder/I required assistance change their incont hours and as need indicated if R3 refu staff were to reapp Review of R3's pro through 6/3/21, lac	as directed by the care plan, (R3) who was always and bladder. (R3) who was always and bladder. (R3) who was always and bladder. (R3) who was always and bladder. (R3) who was always and bladder. (MDS) dated R1 had severe cognitive quired extensive assistance s always incontinent of bowl (der care area assessment 21, indicated R1 was and bladder. The CAA further red staff assistance due to bility to stand or walk. (R4) 5/5/21, indicated R3 had bowel incontinence and a of two staff to check and tinence product every three ed. R3's care plan further sed to be checked or changed,	F 67	responses to each F-Tag a maintain certification in the Medicaid programs and co credible allegation of com- written responses do not o admission of noncomplian agreement with any finding the F-Tags. The facility res- to dispute all findings and any appropriate forum, inc- independent dispute resol appealable remedies are s- imposed, by timely appeal Departmental Appeals Boa R3 was provided assistan- incontinence care upon id has had a Bowel, Bladder assessment completed or ensure that she has been comprehensively assesse plan of care and care sheet individualized needs ident assessment. NAR caring f provided education and co to not following plan of care audit is being completed for residents, including review care sheet, and assessment ongoing compliance and s ADLs for dependent reside The facility has reviewed t	e Medicare and onstitute a pliance. The constitute an ace or gs stated under serves its right deficiencies in cluding in an ution, or, if subsequently to the ard. ce with entification. R3 and Skin Risk or 4/23/2021 to d and that her ets match the ified on this for R3 was baching related re and proper e. A full house or all current of care plan, ents to ensure safety regarding ents. he policy titled	
	observation was co 2:01 p.m. At 10:24	a.m. a continuous onducted from 10:24 a.m. to a.m. R3 was seated in a g television in their room with		Toileting Residents and it appropriate. All nursing st education on the process plan of care is being follow care sheets and shift repo staff will be educated on re	taff are receiving to ensure the ved using the rt. In addition,	

Facility ID: 00975

If continuation sheet Page 2 of 10

STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		245424	B. WING _		C 06/03/2021
	PROVIDER OR SUPPLIER	ARDEN HILLS		STREET ADDRESS, CITY, STATE, ZIP CO 3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112	DE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF	HOULD BE COMPLÉTIO
F 677	(NA)-A entered R3's was ready for lunch dining room without incontinence. At 12 wheelchair and was At 12:41 p.m. R3 re wheelchair in dining staff and residents. 12:55 p.m. R3 remain in dining room and At 12:58 p.m. R3 wa and continued to wa the wheelchair. R3 2:01p.m., after survincontinence cares, offered to help R3 r incontinence cares, offered to help R3 r incontinence cares, be changed and wa television show. R3 incontinent cares for At 3:27 p.m., R3 wa LPN-B. NA-B and L bed. R3 was lifted in R3's clothing and lift with urine and stool redness on R3's but (cm) by four cm and blanchable. R3 wa performed. Prior to reapproach R37 we When interviewed of stated R3 had beer 8:00 a.m. NA-A stat to bed and be chan R3 refused. NA-A care at about 10:45	2:05 a.m., nursing assistant s room and asked R3 if she h. NA-A then brought R3 to the t offering to check for :12 p.m. R3 remained in her s eating lunch in dining room. emained seated in the g room and was visiting with Toileting was not offered. At ained seated in the wheelchair was talking with the Chaplain. as wheeled back to her room atch television while seated in was not offered toileting. At reyor inquiry regarding , NA-A entered R3's room and return to bed and provide . R3 stated she did not want to as concentrating on the b had not been offered or three hours and 37 minutes. as reapproached by NA-B and .PN-B assisted R3 back to nto bed with a hoyer lift and ft sling was noted to be soiled I. LPN-B measured the ttocks to be nine centimeters d verified the red area was s changed and perineal cares 3:27 p.m. no attempts to	F 67	 reapproach in regard to activiliving (ADLs). The facility will complete rand 10% of residents using their of to ensure their services provising compliance with care sheet/care plan wee ongoing compliance with care services. The results of these be reviewed by the Quality Asteam who will determine the forongoing audits. The Clinical Administrator or be responsible for ongoing compliance is Frid 2021. 	dom audits of care sheets ded match kly to ensure es and se audits will ssurance frequency of designee will ompliance;

If continuation sheet Page 3 of 10

NU PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	()	LE CONSTRUCTION		
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à		pleted C
		245424	B. WING			03/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	ARDEN HILLS		3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 677	was sometimes co stated when R3 ref be notified and R3 further stated upon lunchtime and R3 w NA-A verified R3 w every three. Contr upon continuous of R3 were observed. When interviewed stated R3 needed thours and required incontinence cares unaware R3 had ref was not aware how NA-A reported the LPN-A stated wher documented refusa information was als When interviewed stated R3 was inco attempting cares. N cares, staff needed trying. NA-B stated when R3 refused. I	tated R3 refused cares and nfused and combatitive. NA-A fused cares, LPN-A needed to should be reapproached. NA-A n return from break, it was was brought to the dining room. vas to have incontinent cares ary to the above statement, bservation, no attempts to toilet				

If continuation sheet Page 4 of 10

DEPARTMENT OF HEALTH AND HUMAN CENTERS FOR MEDICARE & MEDICAID				FORM	06/30/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/S	UPPLIER/CLIA (X2)	-	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
24	5424 B. V	WING			C 0 3/2021
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBYTERIAN HOMES OF ARDEN HILLS		-	220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING IN	DED BY FULL F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 F 677 Continued From page 4 reapproach should happen within in care was still refused, the nurse im RN-A stated the nurse should also resident. RN-A stated both nurses to document in the EMR when a re- care. When interviewed on 6/2/21, at 4:0 stated R3 needed incontinence can be performed every two to three h stated when R3 refused care, staff reapproach a resident until the car completed. LPN-B stated if reappr not successful a progress note way When interviewed on 6/3/21, at 12 director of nursing (DON) stated th was for staff to follow a resident's DON stated if a resident refused of resident was to be reassessed, or within 30 to 60 minutes. The facility's policy Toileting Resid 12/2014, indicated the level of dep time frame's of the resident's toiled identified on the care plan. and nu monitor for compliance each shift. Treatment/Svcs to Prevent/Heal P CFR(s): 483.25(b)(1)(i)(ii) §483.25(b)(1) Pressure ulcers. Based on the comprehensive asser resident, the facility must ensure th (i) A resident receives care, consis professional standards of practice pressure ulcers and does not devenue ulcers unless the individual's clinic 	essment of a hat- stent with , to prevent elepident of a hat- stent with , to prevent elop pressure	F 677			7/16/21

Facility ID: 00975

If continuation sheet Page 5 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				RINTED: 06/30/2021 FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		245424	B. WING	i		06/03/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-
PRESBY	TERIAN HOMES OF A	ARDEN HILLS			220 LAKE JOHANNA BOULEVARD NRDEN HILLS, MN 55112	
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F 686	 (ii) A resident with professional st promote healing, provide the second state of the secon	hey were unavoidable; and pressure ulcers receives at and services, consistent andards of practice, to revent infection and prevent veloping. NT is not met as evidenced tion, interview, and document illed to implement pressure of turning and repositioning for B) identified at risk for pressure of turning and repositioning for B) identified at risk for pressure ated 6/3/21, indicated ntia without behavioral eart failure. num Data Set (MDS) dated R1 had a severe cognitive ed extensive assistance of two y, and was totally dependent sfers. R3 was noted to have a injury. / Care Area Assessment 1, indicated R3 was at risk for e to incontinence of bowl and d assistance of two staff for us not able to stand or walk. and Skin Risk Summary cated R3 was at moderate risk . R1 was to be repositioned uring the day and every four	F	686	R3 was provided assistance with immediate care upon identification has had a Bowel, Bladder and Skii assessment completed on 4/23/20 ensure that she has been comprehensively assessed and th plan of care and care sheets matc individualized needs identified on t assessment. NAR caring for R3 w provided education and coaching r to not following plan of care, prope process for refusal of care and pot negative outcomes related to these actions. Facility continues to moni skin of R3 through weekly body au with no new findings. A full house a being completed for all current res including review of care plan, care and assessments to ensure ongoin compliance and safety regarding p injury prevention and care. The facility has reviewed the Skin Management Policy and it remains effect. All nursing staff are receiving education on the process to ensure plan of care is being followed using care sheets and shift report. In add staff will be educated on refusals a reapproach in regard to activities of living (ADLs).	n Risk p21 to at her h the his as related er tential e tor the idents, sheet, ng pressure s in ng e the g the dition, and

Facility ID: 00975

If continuation sheet Page 6 of 10

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DAT	0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLETED
		245424	B. WING			C
	PROVIDER OR SUPPLIER	243424	D. WING _	STREET ADDRESS, CITY, STATE, ZIP		03/2021
	NOVIDEN ON SOFTEIEN			3220 LAKE JOHANNA BOULEVAR		
PRESBY	TERIAN HOMES OF	ARDEN HILLS		ARDEN HILLS, MN 55112	-	
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 686	able to ambulate, r for repositioning, a pressure injuries. T R3 was to be repos as needed. If R3's return and reappro R3's progress note through 6/1/21, lac repositioning. On 6/2/21, a contin 10:24 a.m. to 2:01 observed sitting in television in their ro assistant (NA)-A er R3 if she was read R3 to the dining roor repositioning at this seated in her whee dining room. At 12: in the wheelchair ir staff and other resi repositioning. At 12: in her wheelchair ir a Chaplin. At 12:58 their room and was this time. R3 conti seated in the whee entered R3's room and to change R3's she did not want to she was concentra was not offered rep 37 minutes. At 3:27	ed 5/5/21, indicated R3 was not equired assistance of two staff nd was at risk for developing The care plan further indicated sitioned every three hours and refused cares, staff were to	F 68	The facility will complete ra 10% of residents weekly to ongoing compliance with p to prevent pressure injury of directed by the care sheet/ addition, the facility will aud residents with skin issues to ongoing provision of care a their individualized plan of results of these audits will the Quality Assurance team determine the frequency of audits. The Clinical Administrator of be responsible for ongoing the date of compliance is T 16, 2021.	o ensure rovision of care development as care plan. In dit 10% of all to ensure as directed by care. The be reviewed by n who will f ongoing or designee will compliance;	

If continuation sheet Page 7 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245424	B. WING				C 03/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF A	ARDEN HILLS			220 LAKE JOHANNA BOULEVARD RDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	buttocks was varyin extended down to the measured the reduction ine centimeters (c red area was blanch made no attempts the repositioning. When interviewed of stated R3 had been 8:00 a.m. NA-A state to bed and be chan R3 refused. NA-A of care at about 10:45 and R3 was not reach her break. NA-A state was sometimes con- stated when R3 refu- be notified and R3 af further stated upon lunchtime and R3 was three hours. Contra- upon continuous ob reposition R3 were 2:01 p.m. When interviewed of stated R3 had to be hours. LPN-A stated refused repositionin aware how long R3 NA-A informed him R3 refused care, st few minutes. LPN-A refuse, the charge of LPN-A also stated i	ge 7 urine and stool. R3's ing shades of red which he top of their legs. LPN-B ess on R3's buttocks to be m) by four cm and verified the hable. Prior to 3:27 p.m. staff o reapproach R37, to offer on 6/2/21, at 1:54 p.m. NA-A in her wheelchair since about ted R3 was offered to get back ged around 10:45 a.m., but confirmed when R3 refused a.m., LPN-A was not notified pproached as it was time for ated R3 refused cares and infused and combative. NA-A used cares, LPN-A needed to should be reapproached. NA-A return from break, it was vas brought to the dining room. as to be repositioned every ry to the above statement, beervation, no attempts to observed from 10:24 a.m until on 6/2/21 at 2:07 p.m., LPN-A e repositioned every three d he was not notified R3 had ng. LPN-A stated he was not was in their wheelchair until just now. LPN-A stated when aff needed reapproach after a A stated if R3 continued to nurse needed to be notified. f a resident refused cares this ited in a progress notes and	F	886			

Facility ID: 00975

If continuation sheet Page 8 of 10

	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
			/ 20:22			(C
		245424	B. WING			06/0	03/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF A	ARDEN HILLS			3220 LAKE JOHANNA BOULEVARD		
	0				ARDEN HILLS, MN 55112		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	1		<u> </u>				
F 686	Continued From pa	ae 8	Ff	586			
	communicated to th	-					
		on 6/2/21, at 2:21 p.m. NA-B stive to cares, at times. NA-B					
		d, staff needed to reapproach.					
	NA-B stated, at time	es, R3 was agreeable with a					
		A-B stated a nurse needed to					
		3 refused cares. NA-B stated reposition herself in a					
		uired assistance of two staff.					
		efusal of care needed to be					
	documented on the medical record (EM	e task sheet in the electronic					
		on 6/2/21, at 3:21 p.m.					
		N)-A stated it was expected e care plan for the residents.					
		a resident refused care, the					
		reapproach. RN-A stated the					
		happen within the hour and if ed, the nurse must be notified.					
		rse should also approach the					
	resident. RN-A state	ed both nurses and NA's need					
	to document in the care.	EMR when a resident refused					
	Care.						
		on 6/2/21, at 4:00 p.m. LPN-B					
		o be repositioned every two to					
		stated when R3 refused care, pproach a resident until the					
		ted. LPN-B stated if					
		not successful a progress					
	note was needed.						
	When interviewed c	on 6/3/21, at 12:35 p.m.					
	director of nursing ((DON) stated staff were					
		he resident's care plan. The ident refused care, staff must					
		oach within 30 to 60 minutes					

If continuation sheet Page 9 of 10

PRINTED: 06/30/2021

		AND HUMAN SERVICES				FORM	06/30/2021 APPROVED 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245424	B. WING				C 0 3/2021
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	ARDEN HILLS			220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	and follow-up with a document refusals	in their task sheets and nurses care in a progress notes.	F	586			

Facility ID: 00975



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 <u>only a suggestion</u> 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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

Presbyterian Homes Of Arden Hills June 21, 2021 Page 2

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.

· Ping

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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		(X3) DATE COMP	SURVEY LETED
		00975	B. WING		06/0) 3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF A		E JOHANNA	BOULEVARD 5112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction y and identify the date	S: 6/3/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
LABORATOR	epartment of Health 7 DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 06/29/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 12

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00975	B. WING		C 06/03/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		3220 LAI	KE JOHANNA	BOULEVARD		
RESB I	TERIAN HOMES OF	ARDEN HILLS ARDEN H	HILLS, MN 55	112		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
TAG			TAG	DEFICIENC		
2 000	Continued From no		2 000			
2 000	Continued From pa	ige i	2 000			
		plaint was found to be				
		H5424078C (MN70253) with				
	a licensing orders i 0920	ssued at 0840, 0905 and				
	0920					
	The following com	plaint was found to be				
		H5424077C (MN62333),				
		ing orders were issued.				
		nent of Health is documenting				
		Correction Orders using				
		Tag numbers have been sota state statutes/rules for				
		he assigned tag number				
		eft column entitled "ID Prefix				
		atute/rule out of compliance is				
		nary Statement of Deficiencies'	•			
	column and replace	es the "To Comply" portion of				
		r. This column also includes				
		are in violation of the state				
		atement, "This Rule is not met				
		ollowing the surveyor's findings	;			
	Time Period for Co	Method of Correction and				
		participate in the electronic				
		ensure orders consistent with				
	the Minnesota Dep					
		tin 14-01, available at				
		state.mn.us/facilities/regulatio				
		_1.html The State licensing				
		ed on the attached Minnesota				
		Ith orders being submitted to				
		Although no plan of correction ate Statutes/Rules, please				
		RRECTED" in the box				
		ou must then indicate in the				
		ensure process, under the				
		n date, the date your orders wil	I			
	be corrected prior t	o electronically submitting to				

Minnesc	ta Department of He				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	B) DATE SURVEY COMPLETED
		00975	B. WING		C 06/03/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
PRESBY	TERIAN HOMES OF	ARDEN HILLS		BOULEVARD	
			HILLS, MN 55		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From pa	age 2	2 000		
	is enrolled in ePOC	artment of Health. The facility and therefore a signature is bottom of the first page of			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.			
2 840	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 B Adequate and re; Clean skin	2 840		7/16/21
		or determining adequate and criteria for determining er care include:			
	odors. A bathing pl resident's plan of c condition requires t must be given a co other day and more incontinent residen every two hours, ar	and freedom from offensive lan must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every e often as indicated. An t must be checked at least nd must receive perineal care ode of incontinence.			
	Notwithstanding Mi 4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident	1. Incontinent residents. nnesota Rules, part intinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident amily member or legally ator, guardian, or health care who is not competent, agrees obysician involvement in	,		

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING	:	C 06/03/202	
		00975	B. WING			
IAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	ARDEN HILLS	KE JOHANN HILLS, MN 5	A BOULEVARD 5112		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLET DATE
2 840	Continued From pa	age 3	2 840			
		terval, and this waiver is resident's care plan.]				
	promptly each time Perineal care inclu- the perineal area. to keep the bed dry comfort. Special a skin to prevent irrita types of protectors completely covered contact with the res	thing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used y and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be d, and not come in direct sident. Soiled linen and emoved immediately from revent odors.				
	by: Based on observat review, the facility f incontinence care,	ent is not met as evidenced ion, interview, and document failed to implement timely as directed by the care plan, (R3) who was always el and bladder.		Corrected		
	Findings include:					
		ated 6/3/21, indicated entia without behavioral neart failure.				
	4/21/21, indicated l impairment, and re	mum Data Set (MDS) dated R1 had severe cognitive equired extensive assistance s always incontinent of bowl				
	(CAA) dated 1/26/2	lder care area assessment 21, indicated R1 was				
nesota Do TE FORM	epartment of Health M		6899	7RTJ11	If continuatio	n sheet 4

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVE COMPLETED C 06/03/202	
		00975			06/	03/2021
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
RESBY	TERIAN HOMES OF		KE JOHANNA HILLS, MN 55			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
2 840	Continued From pa	age 4	2 840			
	indicated R3 require	and bladder. The CAA further red staff assistance due to bility 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.		,			
		gress notes dated 4/1/21, ked indication documentation				
	observation was co 2:01 p.m. At 10:24 wheelchair watchin the door open. At 1 (NA)-A entered R3 was ready for lunch dining room withou incontinence. At 12 wheelchair and wa At 12:41 p.m. R3 re wheelchair in dinin staff and residents 12:55 p.m. R3 rem in dining room and At 12:58 p.m. R3 w and continued to w the wheelchair. R3 2:01p.m., after sur incontinence cares offered to help R3	4 a.m. a continuous onducted from 10:24 a.m. to a.m. R3 was seated in a ing television in their room with l2:05 a.m., nursing assistant 's room and asked R3 if she h. NA-A then brought R3 to the at offering to check for 2:12 p.m. R3 remained in her s eating lunch in dining room. emained seated in the g room and was visiting with . Toileting was not offered. At ained seated in the wheelchair was talking with the Chaplain. vas wheeled back to her room ratch television while seated in was not offered toileting. At veyor inquiry regarding a, NA-A entered R3's room and return to bed and provide				
	be changed and w	 R3 stated she did not want to as concentrating on the had not been offered 				

IINNESOTA DEPA TATEMENT OF DEP ND PLAN OF CORF	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00975	B. WING	IG		C 03/2021
AME OF PROVIDER	OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		APDEN HULS 3220 LAI	KE JOHANNA	BOULEVARD		
RESBYTERIAN		ARDEN HILLS ARDEN I	HILLS, MN 55 [.]	112		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 840 Contin	ued From pa	age 5	2 840			
inconti At 3:27 LPN-B bed. R R3's cl with ur redness (cm) b blanch perforr reappr When stated 8:00 a to bed R3 refi care a and R3 her bre was so stated be noti further lunchti NA-A every t upon c R3 we	nent cares for p.m., R3 was NA-B and I 3 was lifted othing and li ine and stoo s on R3's buy four cm an able. R3 was ned. Prior to oach R37 was interviewed R3 had been m. NA-A sta and be char used. NA-A stabout 10:45 about	br three hours and 37 minutes. as reapproached by NA-B and _PN-B assisted R3 back to into bed with a hoyer lift and ft sling was noted to be soiled I. LPN-B measured the uttocks to be nine centimeters d verified the red area was as changed and perineal cares 3:27 p.m. no attempts to ere observed. on 6/2/21, at 1:54 p.m. NA-A n in her wheelchair since about ted R3 was offered to get back nged around 10:45 a.m., but confirmed when R3 refused 5 a.m., LPN-A was not notified approached as it was time for tated R3 refused cares and nfused and combatitive. NA-A return from break, it was was brought to the dining room ras to have incontinent cares ary to the above statement, oservation, no attempts to toile	x t			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00975		B. WING			C 03/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RESBY	TERIAN HOMES OF		KE JOHANNA HILLS, MN 551			
(X4) ID	SUMMARY STA	CORRECTION	(X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 840	Continued From pa	age 6	2 840			
	stated R3 was inco attempting cares. N cares, staff needed trying. NA-B stated when R3 refused. N reposition herself in assistance of two to refusal of care need	on 6/2/21, at 2:21 p.m., NA-B ontinent and could resist when NA-B stated when R3 refused to reapproach and keep a nurse should be notified NA-B stated R3 was not able to her wheelchair and required o move. NA-B stated R3's ded to be documented on a ectronic medical record				
	registered nurse (F for NAs' to follow th RN-A stated when NA staff needed to reapproach should care was still refuse RN-A stated the nu resident. RN-A stat	on 6/2/21, at 3:21 p.m. RN)-A stated it was expected he care plan for the residents. a resident refused care, the reapproach. RN-A stated the happen within the hour and if ed, the nurse must be notified. Irse should also approach the ed both nurses and NA's need EMR when a resident refused				
	stated R3 needed i be performed every stated when R3 ref reapproach a resid completed. LPN-B	on 6/2/21, at 4:00 p.m. LPN-B ncontinence care and it was to y two to three hours. LPN-B used care, staff needed to ent until the cares were stated if reapproaching was ogress note was needed.				
	director of nursing was for staff to follo DON stated if a res	on 6/3/21, at 12:35 p.m., (DON) stated the expectation ow a resident's care plan. The sident refused care, the reassessed, or reapproached utes.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED C
		00975	B. WING		06	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF		KE JOHANNA HILLS, MN 55	BOULEVARD		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	age 7	2 840			
	12/2014, indicated time frame's of the	Toileting Residents dated the level of dependence and resident's toileting will be re plan. and nursing will ance each shift.				
	Director of Nursing develop, review, ar procedures to ensu- toileting and proces if a resident refuses could educate all si procedures. The D	THOD OF CORRECTION: The (DON), or designee, could ad/or revise policies and ure residents are offered sses related to reapproaching s. The DON, or designee, taff on the policies and ON, or designee, could systems to ensure ongoing				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	9			
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905			7/16/21
	positioned in good of residents unable must be changed a including periods o been put to bed for has documented th hours during this tin	ng. Residents must be body alignment. The position a to change their own position at least every two hours, f time after the resident has the night, unless the physician nat repositioning every two me period is unnecessary or ordered a different interval.				
	by: Based on observat review the facility fa ulcer interventions	ent is not met as evidenced ion, interview, and document ailed to implement pressure of turning and repositioning for 3) identified at risk for pressure		Corrected		

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00975	B. WING		06/0) 3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	ARDEN HILLS	(E JOHANN/ IILLS, MN 5	A BOULEVARD 5112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 8	2 905			
	ulcers.					
	Findings include:					
		ated 6/3/21, indicated ntia without behavioral eart failure.				
	4/21/21, indicated F impairment, require staff for bed mobilit	num Data Set (MDS) dated R1 had a severe cognitive ed extensive assistance of two y, and was totally dependent sfers. R3 was noted to have a injury.				
	(CAA) dated 1/26/2 pressure ulcers due bladder. R3 require	y Care Area Assessment 1, indicated R3 was at risk for e to incontinence of bowl and d assistance of two staff for as not able to stand or walk.				
	dated 4/23/21, indic for skin breakdown	and Skin Risk Summary cated R3 was at moderate risk . R1 was to be repositioned luring the day and every four ght.				
	able to ambulate, re for repositioning, ar pressure injuries. T R3 was to be repos	d 5/5/21, indicated R3 was not equired assistance of two staff nd was at risk for developing he care plan further indicated itioned every three hours and refused cares, staff were to ach R3.				
		s reviewed from 4/1/21, ked indication R3 refused				
		uous observation from at				
Minnesota D STATE FORI	epartment of Health M		6899	7BT 11	lf continuati	on sheet 9 of 12

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		BERTH TO THOMBEN.	A. BUILDING:			
		00975	B. WING		C 06/03/2	
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RESBY	TERIAN HOMES OF		KE JOHANNA HILLS, MN 55			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 905	Continued From pa	age 9	2 905			
	observed sitting in television in their ro assistant (NA)-A er R3 if she was ready R3 to the dining roo repositioning at this seated in her whee dining room. At 12: in the wheelchair in staff and other resi repositioning. At 12 in her wheelchair in a Chaplin. At 12:58 their room and was this time. R3 contin seated in the whee entered R3's room and to change R3's she did not want to she was concentra was not offered rep 37 minutes. At 3:27 by NA-B and LPN-R R3 back to bed. R3 hoyer lift and R3's o to be incontinent of buttocks was varyin extended down to t measured the redm nine centimeters (or red area was blanc made no attempts repositioning. When interviewed of stated R3 had been 8:00 a.m. NA-A stat to bed and be char	p.m. At 10:24 a.m. R3 was a wheelchair watching born. At 12:05 a.m. nursing intered R3's room and asked y for lunch. NA-A then wheeled of and was not offered a time. At 12:12 p.m. R3 was lichair eating lunch in the 41 p.m., R3 remained seated a dining room and visited with dent. R3 was not offered 2:55 p.m. R3 remained seated in the dining room and spoke to a p.m. R3 was wheeled back to a not offered repositioning at nued to watch television while lchair. At 2:01p.m. NA-A and asked R3 to return to bed incontinent pad. R3 told NA-A go to bed, or be changed, and ting on a television show. R3 positioning for three hours and 7 p.m. R3 was reapproached B. NA-B and LPN-B assisted 8 was lifted into bed with a clothing and lift sling was noted furine and stool. R3's ng shades of red which the top of their legs. LPN-B less on R3's buttocks to be cm) by four cm and verified the shable. Prior to 3:27 p.m. staff to reapproach R37, to offer				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _	·····		
		00975	B. WING		— C — 06/03/	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RESBY	TERIAN HOMES OF					
(X4) ID	SUMMARY ST		HILLS, MN 55	PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 905	Continued From pa	age 10	2 905			
	and R3 was not rea her break. NA-A si was sometimes co stated when R3 ref be notified and R3 further stated upon lunchtime and R3 w NA-A verified R3 w three hours. Contra upon continuous of	5 a.m., LPN-A was not notified approached as it was time for tated R3 refused cares and nfused and combative. NA-A fused cares, LPN-A needed to should be reapproached. NA-A return from break, it was was brought to the dining room ras to be repositioned every ary to the above statement, bservation, no attempts to observed from 10:24 a.m until				
	stated R3 had to be hours. LPN-A state refused repositionin aware how long R3 NA-A informed him R3 refused care, si few minutes. LPN- refuse, the charge LPN-A also stated	on 6/2/21 at 2:07 p.m., LPN-A e repositioned every three ed he was not notified R3 had ng. LPN-A stated he was not 8 was in their wheelchair until 1 just now. LPN-A stated when taff needed reapproach after a A stated if R3 continued to nurse needed to be notified. if a resident refused cares this nted in a progress notes and he next shift.				
	stated R3 was resistated if R3 refused NA-B stated, at time different person. Na be notified when R R3 was not able to wheelchair and reconstruction NA-B stated R3's reference	on 6/2/21, at 2:21 p.m. NA-B stive to cares, at times. NA-B d, staff needed to reapproach. les, R3 was agreeable with a A-B stated a nurse needed to 3 refused cares. NA-B stated reposition herself in a juired assistance of two staff. efusal of care needed to be a task sheet in the electronic <i>I</i> (R).				
		on 6/2/21, at 3:21 p.m.				
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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		00975	B. WING		06/	03/2021
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			
RESBY	TERIAN HOMES OF		KE JOHANNA HILLS, MN 55 [.]			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 905	Continued From pa	age 11	2 905			
	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.					
	stated R3 needed t three hours. LPN-E staff needed to rea cares were comple	on 6/2/21, at 4:00 p.m. LPN-B to be repositioned every two to 3 stated when R3 refused care pproach a resident until the eted. LPN-B stated if a not successful a progress				
	director of nursing expected to follow DON stated if a res reassess or reappr and follow-up with document refusals	on 6/3/21, at 12:35 p.m. (DON) stated staff were the resident's care plan. The sident refused care, staff must roach within 30 to 60 minutes a nurse. The DON stated NAs' in their task sheets and nurses care in a progress notes.				
	director of nursing review and revise p to positioning. The	THOD OF CORRECTION: The (DON), or designee, could policies and procedures related DON, or designee, could train audits to ensure care plans are	1			
	TIME PERIOD FO (21) days.	R CORRECTION: twenty-one				
	epartment of Health					