Electronically delivered
September 16, 2020

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

RE: CCN: 245556
Cycle Start Date: August 31, 2020

Dear Administrator:

On August 31, 2020, a survey was completed at your facility by the Minnesota Department of Health 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 actual harm that was not immediate jeopardy (Level G) as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
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: karen.aldinger@state.mn.us
Phone: 651-201-3794

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board’s Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	C 08/31/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 8/27/20, 8/28/20, and 8/31/20 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 8/27/20, 8/28/20, and 8/31/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. Additionally, a complaint investigation was also conducted. Your facility was found to NOT be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were investigated and found to be substantiated at past non-compliance: H5556036C, H5556037C, H5556038C. Although the provider implemented corrective action prior to survey, harm was sustained prior to correction. Deficiency issued at F689. The following complaint was not substantiated: H5556035C Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		9/29/20

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

Electronically Signed | 09/29/2020

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

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F 689 SS=G	Continued From page 1 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned fall prevention interventions were followed for 1 of 3 residents (R2) reviewed for falls. R2 sustained harm when the care plan was not followed, R2 fell and sustained a pelvic fracture. However, the facility took immediate corrective action, therefore this is being cited at past non-compliance. Findings include: R2's admission Minimum Data Set (MDS) dated 6/29/20 included, severe cognitive impairment with diagnoses including recent fall with hip fracture and Alzheimer's disease. R2 was unsteady with transfers and required 2 plus physical assist with transfers and ambulation. R2's fall Care Area Assessment (CAA) dated 7/1/20, included being at risk for falls related to a fall prior to admission which resulted in a left femur fracture. Other risk factors included, severe cognitive impairment, weakness, impaired balance, cardiac and respiratory impairments, incontinence, use of psychotropic, cardiac and diuretic medications and behavior concerns.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

R2's progress note dated 8/1/20, included, "Pt [patient] was found sitting on the floor with her back against the front of the reclining chair. Pt is unable to give specific data on what she was trying to do that caused her to fall. After assessment, pt was picked up from the floor using the full mechanical lift." An immediate intervention was, "Pin call light on pt." An interdisciplinary note, dated 8/3/20, noted, "Root cause analysis: Pt was trying to get comfortable when she slid out of the chair. Intervention based on root cause analysis. Ensure legs are elevated in recliner when not eating. Evaluation of intervention: Pt states she is more comfortable with her feet up."

R2's Falls Follow Up Form dated 8/1/20, included R2 had fallen and the, "Short Term Intervention" was to, "Clip call light on Pt [patient]." This form was updated on 8/3/20, and included, "Ensure foot rest of recliner is up, except meal times. Pt tends to lean back and slide he [sic] butt forward trying to get comfortable."

R2's risk for falls care plan dated 8/21/20, directed staff to keep call light within reach, "Check my O2 sats [oxygen level] before I get out of bed in the morning," and, "Ensure my feet are elevated in the recliner except during meal times." R2's care plan also addressed sleep apnea and directed staff to use a CPAP machine [continuous positive airway pressure machine that aides in breathing for obstructive sleep apnea] at night, "but often refuses to use it."

R2's Pathway RA [resident assistant] Group Sheet, dated 8/19/20, directed staff, "Ensure legs elevated in recliner when not eating. Keep walker within reach."

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F 689	Continued From page 3	F 689		

R2's progress note, dated 8/15/20, included, "Resident observed on floor at 0840 [8:40 a.m.] after writer heard sound of fall and resident shouting for help. Resident states she hit her head, no swelling noted, resident denies tenderness to palpitation of entire head area. Resident able to move all extremities PR [pulse rate] BP [blood pressure] stable. Resident alertness and communication pattern at baseline for resident, PERRL [pupils equal, round, and reactive to light]. Resident assisted from floor to recliner using Golvo lift [mechanical lift] A2 [assist of two staff]. Resident tolerates transfer with no complaints of pain. Intervention based on root cause analysis: Foot rest elevated per care plan after transfer to chair. ST [short term] intervention: Leave walker adjacent to resident." and "Describe Injury: Denies headache or tenderness. Moves all extremities. Resident pleasant with staff this shift. Writer attempted to assist resident to standing position and to ambulate before lunch. Resident demonstrates pain upon standing and is unwilling to take a step due to fear of pain." The note identified a nurse practitioner was notified and lab work for R2's blood thinner and an X-ray was ordered.

R2's x-ray, dated 8/15/20, noted, "Right superior and inferior pubic ramus [pelvic] fracture."

R2's nurse practitioner progress note dated 8/17/20, identified, "8/15 had fall from recliner. Staff reports that usually they have legs elevated but recliner was left down and the patient attempted to self transfer. Oximeter initially read 75-85% but later was 90%. CXR [chest x-ray] done showed chronic lung findings with developing LLL [left lower lobe] infiltrate. 8/16

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sent to Methodist ED [emergency department] for concerns of hip pain/right groin pain and not wanting to bear weight. Recent left hip fracture with repair 6/19. At Methodist-right pelvic fracture, no issues with hip replacement. COVID negative. CT [cat scan] head negative for acute changes. Returned to facility same day."

R2's investigation report from the fall on 8/15/20, dated 8/21/20, included, "RA [resident assistant] indicated that she did not elevate footrest of the recliner upon leaving VA's [vulnerable adult] room per the VA's previously stated preference and care plan." "During the interview with the resident assistant (RA) on duty at the time of the fall, the RA described helping the VA with AM cares and toileting prior to assisting VA to recliner. The RA placed the tray table on the side of recliner and call light within reach. The RA then left to retrieve the VA's breakfast tray. The VA was heard yelling by the nurse on duty and was found on the floor between the bed and the recliner. The VA was unable to verbalize what she was trying to do at the time of the fall. The RA noted upon her return to the resident that she had been gone approximately 2 minutes. Medical record review and nurse interview indicated that the VA experienced a period of decreased saturations (75%-85%) [normal oxygen saturation level 95-100%] noted during vital signs check after the fall. The nurse verified with 4 different oximeters and was able to obtain a reading of 90% after a period of time. The Nurse noted 'they started low and slowly went up.' The On-call MD was updated and orders for chest x-ray and COVID-19 swab were given and carried out. The NP [nurse practitioner] indicated that the VA has a history of Obstructive Sleep Apnea and refusal of wearing CPAP and that this may have been a

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contributing factor to the low O2 level [oxygen level] The Director of Nursing interviewed the NP and she assessed VA on 8/17/2020 and VA was not symptomatic for pneumonia or other respiratory illness. A review of the progress notes indicated that overnight VA had displayed confusion, restlessness and combative behaviors. Psychotropic medication was increased after a failed GDR [gradual dose reduction] on 8/7/2020. The RA noted that VA was not wearing her CPAP when she initiated AM [morning] cares. During RA interview, RA indicated that she did not elevate footrest of the recliner upon leaving VA's room per per the VA's previously stated preference and care plan. The RA also stated that when she left the room, the VA did not recall that her assistive device was in within [sic] reach. The RA stated, "I didn't do it on purpose, It just escaped my mind." When asked if RA knew the VA's care plan, she responded yes. She also verbalized carrying the assignment sheet on the day of the fall and previously demonstrating the ability to adhere to the care plan. Upon return from the ER [emergency room], the intervention implemented was to ensure assistive devices are within reach. After further investigation, root cause of the fall was determined to be low saturations due to VA refusal of CPAP overnight. Intervention is for an overnight oximetry [oxygen level] study to be completed and staff to check oxygen saturations prior to assisting VA out of bed for morning cares. The RA was immediately placed on administrative leave and remains on leave while termination is in process. Facility education was completed on following the care plan. Random audits will be completed on each household on a weekly basis to ensure compliance with education. Oximeters were checked and are all functioning properly.

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F 689	Continued From page 6	F 689		

The NP ordered an overnight oximetry study to be completed to determine the need for supplemental oxygen. The VA remains in the facility and is currently utilizing the stand lift with assist of one and is participating in therapy for rehab.

When interviewed on 8/27/20, at 10:50 a.m. licensed practical nurse (LPN)-A stated, R2 needed to have her feet elevated when she was sitting in the recliner for her safety and comfort. Otherwise, R2 sat at the edge of her chair making her at risk for falling.

When observed on 8/27/20, at 11: 56 a.m. nursing assistant (NA)-A was observed assisting R2 with transferring from her recliner to the toilet. NA-A lowered the feet to the recliner. R2 was seated on a cushion in the chair. With the foot of the recliner down, R2 stiffened up her body, with her feet and legs up and angled, pointed away from recliner and upper body leaning back, but not against recliner. R2 verbalized, "oh, oh, oh." NA-A assisted R2 with transferring to the toilet and then back to the recliner. Upon returning to the recliner, R2 sat on the edge of the recliner with her feet off the floor and stiffened up again. NA-A prompted R2 to scoot back in the chair. NA-A did not scoot back in the chair. NA-A advised R2 he would put the recliner feet up and elevated R2's feet and legs. Once the foot rest was elevated R2 appeared to sit comfortably in the chair.

When interviewed on 8/27/20, at 12:05 p.m. NA-A stated. R2 had to have the recliner legs up or R2 would think she could stand, R2 may also slide and was apt to fall out of the chair when the foot rest was down. Stating, R2 was evidently more

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comfortable with the foot rest elevated.

When interviewed on 8/27/20, at 1:44 p.m. NA-B stated she had worked with R2 on 8/15/20. NA-B stated she had prepared R2 for her meal by placing the foot rest down and placed a tray table in front of her, then left the room to obtain the meal tray. She was gone for a couple minutes and when she returned, R2 had fallen out of the chair. NA-B stated R2's care plan directed the foot rest be elevated unless R2 was eating, but she had forgotten to make sure it was elevated when she left R2 alone.

When interviewed on 8/27/20, at 2:59 p.m. Registered nurse (RN)-A stated she was working at the facility on the day of R2's fall, 8/15/20. RN-A stated she had assessed R2 after the fall on 8/15/20, and noted no injuries, but later in the day R2 was hesitant to stand up and reported groin pain. RN-A contacted the physician and received an order for an x-ray. RN-A stated R2's recliner was supposed to be elevated unless she was eating as she was at risk for falling out of the chair due to attempts to get up on own and general discomfort with the foot rest down.

When interviewed on 8/27/20, at 3:27 p.m. R2's registered nurse and nurse manager (RN)-B explained R2 had two falls. The first fall on 8/1/20, R2 slid out of the recliner as she was trying to get comfortable. RN-B explained R2 tended to like to lean back and adjust herself that way. R2's, "butt was way too close to the end of the chair when she sat down." Following the fall on 8/1/20, an intervention was added to elevate feet when R2 was not eating. RN-B explained R2's recliner foot rest should be up unless she was eating, including when staff left room to get

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F 689	Continued From page 8 R2's meal trays. When interviewed on 8/28/20, at 8:58 a.m. the director of nursing (DON) reported the facility determined R2's recliner foot rests were not elevated at the time R2 fell on 8/15/20, and should have been. The DON stated R2's oxygen level related to her not wearing her CPAP contributed to the fall. Immediately, the facility re-educated all nursing staff on ensuring each resident's care plan was being followed and started audits to ensure compliance. The audits were for any resident at risk for falls to ensure their care planned interventions were being followed. The facility fall prevention and management program policy, last revised, 10/2018, directed staff, "Care plans will indicate the resident specific interventions to prevent falls. Nursing staff will implement interventions according to resident specific risk factors." The past non-compliance that began on 8/15/20, was verified during the 8/31/20 onsite visit and was corrected by the facility on 8/16/20. Verification of the corrective action was confirmed by interview with a variety of nursing staff who had received education on ensuring fall prevention interventions were always implemented. In addition facility documentation showed staff had been trained and audits were being completed to ensure fall interventions were being implemented.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 16, 2020

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

Re: Event ID: VLW911

Dear Administrator:

The above facility survey was completed on August 31, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
Complaint investigations were conducted on 8/27/20, 8/28/20, and 8/31/20, to investigate complaints H5556035C, H5556036C, H5556037C and H5556038C. As a result the following was identified:

The following complaints were found to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00189	A. BUILDING: _____ B. WING _____	C 08/31/2020

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2 000	Continued From page 1 substantiated: H5556036C, H5556037C, H5556038C. However, no licensing orders were issued. The following complaints were found to be unsubstantiated: H5556035C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		