STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245613	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes of North Oaks	5919 Centerville Road North Oaks, MN 55127

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 49657 Based on observation, interview and document review the facility failed to post accessible contact information of all pertinent State agencies or Ombudsman information for 4 or 4 residents (R12, R20, R46, and R47), who routinely attend resident council. This had the potential to affect all 52 residents who resided in the facility. Findings include: During the resident council meeting held on 9/25/24 at 10:01 a.m., with a state surveyor, R12, R20, R46, and R47 participated and indicated they were regular attendees of the Resident Council meetings in the facility. Upon asking, R12, R20, R46, R47 stated they were unaware of who the ombudsman was and did not know where the ombudsman information was located or posted in the building. While on survey in the facility from 9/23/24 through 9/26/24, no posting or contact information for the Ombudsman was observed or noted within the facility or on the additional units of the nursing home and were not accessible to the residents to view or read. On 9/25/24 at 2:40 p.m., the director of Nursing (DON) and the administrator confirmed the Ombudsman contact information was not posted. Both the DON and the administrator stated they believed social services had the information; however, it was not posted or visibly readable or accessible by the residents or visitors unless they were to ask for it. On 9/25/24 at 2:58 p.m., during an additional interview, the administrator provided the contact business card/handout for the ombudsman and confirmed again the information was not posted in the facility. On 9/26/24 at 8:34 a.m., the DON confirmed the ombudsman contact information was not posted and was important to post and provide contact information as the Ombudsman was an advocated for the resident and should be available to them as a support system. A policy regarding the Ombudsman information was requested and none was provided.

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on interview and document review, the facility failed to hold, at a minimum, quarterly care conference meetings with the resident and their representative to allow the resident and/or representative the opportunity to review and participate in the revision of the care plan for 1 of 2 residents (R13) reviewed for care conferences. Findings include: R13's quarterly Minimum Data Set (MDS), dated [DATE], indicated R13 was admitted to the care facility on 8/28/24 and was cognitively intact. R13's electronic medical record (EMR) indicated the most current care conference was documented on 1/23/24. The care conference note, dated 1/23/24, indicated the care conference was held on 1/5/24 with R13's family, clinical staff, life enrichment, social services and R13 present. During an interview on 9/26/24 at 8:04 a.m., nurse manager and registered nurse (RN)-A confirmed R13 had not had a care conference since the documented care conference on 1/5/24. RN-A stated there had been a care conference set up but R13's representative was unavailable and it fell through the cracks. RN-A further stated regular care conferences were important to keep families up to date on how the resident was doing. During an interview on 9/23/24 at 2:00 p.m., R13 was unable to state when he last attended a care conference and appeared to have confusion on why he was still living at the care facility, stating multiple times he unsure why he lived at the care facility. During an interview on 9/25/24 at 12:30 p.m., social worker (SW)-A stated it was her role to schedule care conferences, and it was expected to hold a care conference for each resident at admission, quarterly and if a resident had a change in condition. SW-A stated she would reach out to the resident's family (representative), typically via email, set a date and time for the care conference and ensure staff and family were aware. During a follow up interview on 9/25/24 at 2:30 p.m., SW-A confirmed there had not been a documented care conference for R13 since 1/5/24. SW-A stated she and the nurse manager helped arrange a video call between R13 and family on Fridays, stating the nurse manager sat in on one but it was not documented. A facility policy titled Care Plan Policy and Procedure, modified 11/22, indicated a resident's care plan would be reviewed at least quarterly and with any significant change and would not be complete until a care conference was held to review with the resident and/or resident representative.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657 Based on interview, and document review, the facility failed to implement interventions to prevent further development of decreased range of motion for 3 of 4 residents (R2, R4, and R28) reviewed for positioning and mobility. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 was admitted to the facility on [DATE] and had a moderate cognitive impairment and the following diagnoses: Hypertension (HTN) (high blood pressure), diabetes, hyperlipidemia (HLD) (elevated levels of fat in the blood), Parkinson's disease, epilepsy (seizure disorder), anxiety and depression. R2's Care plan dated 9/26/24, included an ambulation program to walk 400 feet with assistance twice a day. An active range of motion (ROM) program for bilateral (both sides) upper extremities five repetitions twice daily. Finally, an active ROM program to bilateral upper and lower extremities daily. The facility document R2's Tasks dated 9/26/24, where staff document the completion of tasks, included an ambulation program to walk 400 feet with assistance twice a day. An active ROM program for bilateral upper extremities five repetitions twice daily. Finally, a ROM program to bilateral upper and lower extremities 10 times daily. R2's Follow-up question report dated 7/26/24 through 9/24/24, included the documentation for the ROM program for bilateral upper extremities to be completed with five repetitions twice daily. For the 60 days reviewed and 120 documentation opportunities the following information was documented: Task completed: 45/120 Not applicable: 40/120 Resident Refused: 30/120 Missed/No documentation: 5/120 R2's follow up question report dated 7/26/24 through 9/24/24, included the documentation for the ambulation program to be completed twice daily. For the 60 days reviewed and 120 documentation opportunities the following information was documented: Task completed: 56/120 Not applicable: 33/120 Resident Refused: 25/120 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Missed/No documentation: 6/120 R2's Follow up question report dated 8/26/24 through 9/24/26, included the documentation for the ROM program to bilateral extremities 10 repetitions daily. For the 30 days reviewed and 30 documentation opportunities the following information was documented: Task completed: 20/30 Not applicable: 7/30 Resident Refused: 2/30 Missed/No documentation: 1/30 R2's medical record lacked any documentation as to why the program was not completed or the rational for not applicable being documented. R4's quarterly MDS dated [DATE], indicated R4 was admitted to the facility on [DATE] and had a severe cognitive impairment and the following diagnoses: Alzheimer's, depression, and psychotic disorder. R4's care plan dated 9/26/24, indicated a ROM program to be completed daily to bilateral lower extremities. The facility document, R4's Tasks dated 9/26/24, included a ROM program for 10 repetitions to bilateral upper extremities to be completed daily and a passive ROM program to lower extremity 10 repetitions daily. R4's occupational therapy (OT) discharge summary dated 7/3/24, indicated discharge recommendations to complete daily ROM to bilateral upper extremities. R4's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to bilateral upper extremities 10 repetitions daily. For the 60 days reviewed and 60 documentation opportunities the following information was documented: Task completed: 43/60 Not applicable: 12/60 Resident Refused: 4/60 Missed/No documentation: 1/60 R4's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to bilateral lower extremities 10 repetitions daily. For the 60 days reviewed and 60 documentation opportunities the following information was documented: Task completed: 43/60 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not applicable: 14/60 Resident Refused: 2/60 Missed/No documentation: 1/60 R4's medical record lacked any documentation as to why the program was not completed or the rational for not applicable being documented. R28's quarterly MDS dated [DATE], indicated R28 was admitted to the facility on [DATE] and had a moderate cognitive impairment and the following diagnoses: cerebral vascular accident (CVA) (stroke), HTN, gastroesophageal reflux disease (GERD), HLD, thyroid disorder, hemiplegia or hemiparesis (unable to use or more one side of the body), and depression. R28's Care plan dated 9/26/24, included a passive range of motion program for the left upper extremity with 10 repetitions daily. A passive ROM program to the left lower extremity with 20 repetitions daily. The facility document R28's Tasks dated 9/26/24, included a ROM program for 10 repetitions to left upper extremity to be completed daily and a ROM program to lower left extremity 20 repetitions daily, and a passive ROM program to the left hand to be completed three times daily. R28's OT discharge summary dated 1/30/24, indicated discharge recommendations to complete daily gentle ROM before and after removing R28's left hand splint. R28's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to the left upper extremity 10 repetitions daily. For the 60 days reviewed and 60 documentation opportunities the following information was documented: Task completed: 25/60 Not applicable: 19/60 Resident Refused: 14/60 Missed/No documentation: 2/60 R28's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to the left lower extremity 20 repetitions daily. For the 60 days reviewed and 60 documentation opportunities the following information was documented: Task completed: 20/60 Not applicable: 24/60 Resident Refused: 14/60 Missed/No documentation: 2/60 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's Follow up question report dated 7/26/24 through 9/24/26, included the documentation for the ROM to the left hand three times daily. For the 60 days reviewed and 180 documentation opportunities the following information was documented: Task completed: 37/180 Not applicable: 47/180 Resident Refused: 31/180 Missed/No documentation: 65/180 R28's medical record lacked any documentation as to why the program was not completed or the rational for not applicable being documented. On 9/25/24 at 1:12 p.m., the nursing assistant (NA)-A stated the NA's usually completed the ROM programs with the residents based on the directions they have on their care sheets, and would sometimes put not applicable if they did not have time to complete the ROM or if it was not completed. On 9/25/24 at 12:04 p.m., registered nurse (RN)-B stated the NA's were responsible for completing the ROM programs, and would sometimes put not applicable if the resident was not on the unit or if it was not completed. On 9/25/24 at 12:55 p.m., the RN clinical coordinator, RN-C stated the NA's were responsible for completing the ROM program and walking programs. RN-C stated their expectation was if the program was scheduled for daily, twice, or three times daily it should have been completed as often. RN-C confirmed that R2, R4, and R28's ROM programs were not being completed as ordered. RN-C stated further there was really no reason for not applicable to be documented, either there was not enough time to complete the ROM or it was not completed. On 9/26/24 at 8:34 a.m., the director of nursing (DON) confirmed that R2, R4, and R28's ROM programs were not being completed as ordered, and they expected the ROM programs for all residents to be completed every day as ordered. The DON confirmed the importance of completing the ROM programs for residents to maintain their level of functioning and to prevent contractures and maintain their ability levels. The Range of Motion policy was requested and it was not provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to act upon the consultant pharmacist's recommendation for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include: R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 with diagnoses of heart failure, diabetes, dementia, and anxiety and documented R11 receiving High-Risk Drug Classes of antipsychotic, antianxiety, antidepressant, opioid, antiplatelet, and hypoglycemic medications. Also, the MDS documented R11 receiving antipsychotic on a routine and as needed (PRN) basis. In addition, the MDS documented R11 on hospice. Insulin R11's physician orders (PO) dated 8/24/24 documented, Humalog Injection Solution (fast acting insulin that lowers blood sugar in adults and children with diabetes) 100 UNIT/ML (milliliter), Inject as per sliding scale (adjusting the insulin dose based on blood glucose level) : if 200-250=2 units; 251-300=3 units; 301-350=4 units, 351-400= 5 units Call Hospice for BG>400, subcutaneously before meals for Sliding Scale to be given in addition to Scheduled 6 units SQ (subcutaneous-injection of medication between skin and muscle) TID (three times per day) before meals. R11's PO dated 9/13/24 documented, Lorazepam Oral Tablet 0.5 mg (milligram), Give 0.5 mg by mouth three times a day for Anxiety AND Give 0.5mg by mouth every 2 hours as needed (PRN) for Anxiety for 30 days. Sliding Scale Insulin R11's electronic medical record (EMR) progress note (PN) titled Pharmacy Monthly Medication Review (MMR)-Recommendation dated 5/13/24 documented, Medication regimen reviewed. See communication with MD and/or Nursing regarding: SSI (sliding scale insulin) . R11's Consultant Pharmacist Communication to Physician (CPCP) form dated 5/13/24 documented: HOSPICE resident has orders for Sliding Scale Insulin (SSI). AGS Beers criteria places SSI under the Strongly 'Avoid' category, due to the: 'Higher the risk of hypoglycemia without improvement in hyperglycemia management regardless of care setting.' CMS considers hypoglycemia an adverse event as it can contribute to falls and has been one of the top reasons for hospital readmissions. CMS guidelines suggest that continued or long-term need for sliding scale insulin for non-emergency coverage may indicate inadequate blood sugar control' and would result in increased scrutiny. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Benefits of moving away from SSI: -Reduced hypoglycemic episodes -Reduced falls -Reduced hospital re-admission -Reduced facility cost -Reduced staff time -Reduced potential F-tags during surveys -Improved patient convenience & quality of life Would you please assess if we could increase basal insulin to limit/eliminate SSI use? Document marked by Other and handwritten managed by Allina Endocrinology-Dr Ibid. Document signed by provider with date of 9/24/2024. Ativan R11's EMR PN titled Pharmacy MMR-Recommendation dated 6/11/24 documented, Medication regimen reviewed. See communication with MD and/or Nursing regarding: Ativan. R11's CPCP form dated 5/13/24 documented: Has orders for PRN Ativan Beers list (a medication guideline from the American Geriatrics Society to help providers safely prescribe medications for adults over age 65) states: 'Avoid benzodiazepines (any type) for treatment of insomnia, agitation, or delirium. Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents. In general, all benzodiazepines increase the risk of cognitive impairment, delirium, falls, fractures, and motor vehicle accidents in older adults. May be appropriate for seizure disorders, rapid eye movement sleep disorders, benzodiazepines withdrawal, ethanol withdrawal, severe generalized anxiety disorder, periprocedural anesthesia, and end-of-life care.' ***New CMS guidelines*** state that for non-antipsychotic psychotropic drugs (anxiolytics, hypnotics .), PRN use should be limited to 14 days UNLESS the prescriber documents the rationale for a longer duration of use in the resident's medical record, an indicated the duration for the PRN order. The CPCP was signed by provider on 9/24/24 with clinical indication for use. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with director of nursing (DON) on 9/24/24 at 3:50 p.m., DON verified R11's 5/13/24 and 6/11/24 CPCP forms were scanned into the EMR but not signed by physician or provider as having been reviewed. I don't know why there is not one [sic] I cannot find it. During interview with DON on 9/25/25 at 9:12 a.m., DON provided surveyor with 5/13/24 and 6/11/24 CPCP forms that were signed by the nurse practitioner (NP) on 9/24/24. During interview with consultant pharmacist (CP) on 9/25/24 at 10:03 a.m., CP stated he is on-site at least once a month and talks to staff about any medication concerns. CP stated his process for monthly medication reviews (MMR) is to review with staff any concerns about medication management and he then documents in the CPCP form what his recommendations are. The form will then be provided to the DON who will follow up by faxing it or providing it to the provider for a signed response. After a signed response is obtained from the provider then the order is updated in the EMR, and the signed form is downloaded into the residents EMR. CP stated, I do not communicate with the hospice provider, and I do not communicate with Endocrinology. It is up to the facility to make sure they are doing it [forwarding the recommendations to the appropriate provider]. CP stated they were unaware the 5/13/24 and 6/11/24 MRR's were not signed by provider until 9/24/24. During interview with NP on 9/26/24 at 9:31 a.m., NP stated the process for her responding to the monthly pharmacist recommendations is the facility provides her a stack of CPCP forms once a month to review. NP stated the facility will receive the signed CPCP forms from her, and the facility will then update the orders in the EMR and scan the form into the EMR. If a resident is on hospice, then the hospice provider and NP work together to collaborate on a response. NP stated if the facility has difficulty getting a response from outside providers or hospice then she is asked to review the CPCP form. NP stated she was out of town in May of 2024 and the hospice provider was out of town in June of 2024 which, could explain the lack of response for the 5/13/24 and 6/11/24 MRR's. NP verified she was provided the 5/13/24 and 6/11/24 CPCP forms by the facility to review and signed them on 9/24/24. NP also stated the endocrinologist mentioned in the 6/11/24 CPCP form was no longer involved in managing R11's insulin and that the hospice provider and NP are now managing it. During interview with DON on 9/26/24 at 9:51 a.m., DON stated it was the facility's responsibility to forward the monthly CPCP forms to the appropriate provider to review and expect a response. DON stated he did not know why the 5/13/24 and 6/11/24 CPCP forms were not signed or forwarded to NP and the hospice provider to review before 9/24/24 but that it should have been. Facility policy titled Psychotropic and Unnecessary Medication Use modified July 2024 state, All pharmacist recommendations will be reviewed with the primary physician/NP prior to implementation and with a physician's order.