Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 15, 2022

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: CCN: 245618
Cycle Start Date: June 14, 2022

Dear Administrator:

On August 2, 2022, the Minnesota Department(s) of Health and Public Safety, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	C 06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	**61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118**

(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 On 6/12/22 to 6/14/22, a survey for compliance with the Appendix Z - Emergency Preparedness Requirements was conducted during a standard recertification survey. Walker Methodist Westwood Ridge II was found in compliance with the requirements. 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.	E 000		
F 000	INITIAL COMMENTS On 6/12/22 to 6/14/22, a standard recertification survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDS). In addition, multiple complaint investigations were completed. Walker Methodist Westwood Ridge II was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5618027C (MN82736); with non-compliance cited at F755. The following complaints were found to be unsubstantiated: H5618024C (MN72605) H5618025C (MN80353) H5618026C (MN82457) H56182187C (MN84126)	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2022

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 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		7/31/22

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F 585	Continued From page 2 of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately	F 585		

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F 585	Continued From page 3 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure voiced grievances about potentially rude or undignified care were addressed in a timely manner and in accordance with established policies and procedures for 1 of 2 residents (R1) reviewed who voiced concerns about their provided care. Findings include:	F 585	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	

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F 585	Continued From page 4 R1's Brief Interview for Mental Status (BIMS), dated 5/31/22, identified R1 had intact cognition. On 6/12/22, at 3:26 p.m., R1 was interviewed and expressed she was not always treated with respect and dignity by "one particular person" who worked at the nursing home. R1 identified nursing assistant (NA)-B by name and explained they demonstrated "extremely poor customer service" by often not helping her with cares she requested and not answering her call light timely. R1 explained awhile earlier on the same day (6/12/22), she had turned her call light on for a ride in her wheelchair down to the dining room for the lunch meal. NA-B responded to the call light and told R1 they would not give her a ride as it was too late and she could eat in her room. This made R1 feel upset and like she "wasn't important" enough to help. R1 stated she reported this incident to registered nurse (RN)-C shortly after it happened; however, she continued to be anxious about the situation. Further, R1 stated these interactions had been happening with NA-B since she admitted to the nursing home and nobody from management had discussed them with her or helped to resolve them. When interviewed on 6/12/22, at 3:35 p.m., RN-C verified R1 had reported concerns to her earlier about NA-B. RN-C explained she entered R1's room around lunch time and found R1 crying, upset and voicing she "always has to wait." R1 expressed NA-B always would tell her they were busy and would not always help her when she needed care or assistance. RN-C stated she repeatedly apologized to R1 for the incident. Further, RN-C stated she had not yet followed up	F 585	Deficient practice identified: The facility failed to ensure voiced grievances about potentially rude or undignified care were addressed in a timely manner and in accordance with established policies and procedures for 1 of 2 residents. Immediate action taken: Administrator was notified of R1's potential grievance and immediately investigated. R1 was offered and accepted a change of rooms based on her preference and relationship with other staff from prior stays. Education with staff occurred on proper communication with residents, treating residents in a respectful manner, and customer service standards. Investigation revealed nurse manager was notified of the grievance at the time of the concern and immediately worked with resident to address and resolve the issue. Res verbalized to nurse manager she felt safe and offered no other concerns. Nurse manager then reported appropriately to DON. R1 discharged from facility on 6/17/22 with no other concerns. Other residents have the potential to be affected. No other grievances were reported or received. Customer service surveys are completed by social services shortly after admission. Social services check with resident satisfaction regularly throughout their stay. Systematic change(s) to ensure deficient practice does not recur:	

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F 585	Continued From page 5 with the aide involved in the concern or reported the incident to anyone in management as it was busy and she hadn't had a chance yet. On 6/12/22, at 3:39 p.m., the surveyor notified the administrator of R1's voiced concerns. The administrator stated he would follow up on the concerns immediately. When interviewed on 6/13/22, at 1:22 p.m., NA-E stated she had worked with R1 a few times since she admitted to the nursing home. NA-E stated R1 had voiced there was an aide who was "not her favorite" to work with as the aide "just doesn't meet her needs." NA-E identified NA-B by name as the person R1 expressed this concern over, and NA-E stated R1 had been voicing concerns about NA-B "ever since she's been here." NA-E stated she did not report these comments to anyone else, including management staff, as she believed R1 had already directly reported them herself. R1's medical record was reviewed and lacked evidence R1's voiced grievances and/or concerns about NA-B had been acted upon or addressed to ensure safe and courteous care was being provided. Further, there was no evidence in the record or provided by the facility demonstrating these repeatedly voiced grievances about care had been acted upon to ensure resolution and prevent reoccurrence despite R1 voicing these concerns to direct care staff since she had admitted to the nursing home as described by NA-E. When interviewed on 6/13/22, at 1:56 p.m., NA-B stated they had worked at the nursing home for several years and recalled working with R1 the	F 585	• The grievance policy was reviewed and remains current. • Staff reeducated on policy to report grievances/concerns to their supervisor, DON, social worker, or administrator. • Will complete two (2) weekly random audits for staff on what to do if a resident reports a grievance. Required monitoring to ensure deficient practice will not recur: Audit findings to be reported to the QAPI committee on a monthly basis for 3 months to ensure proper compliance and appropriate follow up has occurred in a timely manner. Person Responsible: Administrator	

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F 585	Continued From page 6 previous day. NA-B explained they had brought R1's meal tray to her room for the lunch meal but R1 was not in the room, so there had been a delay in getting her the meal; however, NA-B denied R1 ever asked to be brought down to the dining room. NA-B stated R1 had expressed concerns about the care they provided in the past. both during previous admissions to the nursing home and in the past weeks, but they attributed those concerns not with the care provided but rather R1's enjoyment of working with another specific aide more. As a result, NA-B stated there had been a nurse who had approached them about switching groups with another aide to help reduce interactions and care between themselves and R1 about a week prior. Further, NA-B stated they had never been questioned or had the concerns raised by R1 discussed with them by management. On 6/14/22, at 1:46 p.m., the administrator and licensed social worker (LSW)-A were interviewed, and LSW-A verified she was the designated grievance officer for the nursing home. LSW-A and the administrator both verified the alleged incident between NA-B and R1 on 6/12/22 was the first time they had been made aware of any concerns R1 had with NA-B. The administrator explained the grievance process usually starts "as soon as we get a complaint" and an investigation into the allegation or concern is started "right away." LSW-A stated the direct care staff were typically "very good" at bringing concerns forward; however, herself and the administrator both expressed they were not sure why the potential concerns were not brought to them sooner if direct care staff were hearing them since R1 admitted nearly two weeks prior. LSW-A speculated the direct care staff not hearing	F 585		

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F 585	Continued From page 7 "trigger words" which could indicate potential abuse (i.e., threatened, rough) maybe lead to the staff not recognizing the need to bring the concerns up to management; however, LSW-A and the administrator both acknowledged voiced concerns with care should be brought forward so they could be addressed. This was important to do as they want to ensure there were no safety concerns or potential abuse happening. The administrator added, "We need to follow up." A provided Issue and Concern - Skilled policy, dated 11/2016, identified issues and concerns include respect to care and treatment which has or has not been provided and the behavior of workforce members. The policy outlined, "Reporting of issues and concerns is not limited to a formal or written process, but may include a resident's verbalized complaint. All issues and concerns will be addressed in a timely manner." The policy continued and explained the issue or concern would be reviewed including, "Take immediate action to prevent further potential violations to any resident's rights, while the issue or concern is being investigated."	F 585		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		7/31/22

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F 623	Continued From page 8 (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F 623		

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F 623	Continued From page 9 including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the	F 623		

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F 623	Continued From page 10 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure written notification was provided at the time of transfer to an acute-care hospital and the Office of the State Long-Term Care (LTC) Ombudsman was notified in a timely manner for 4 of 4 residents (R19, R13, R25, R26) reviewed for hospitalization. Findings include: R19's admission Minimum Data Set (MDS), dated 3/23/22, indicated R19 had severe cognitive impairment, and several medical diagnoses including kidney failure, disorientation, and dementia with behavioral disturbances. R19's progress note dated 3/30/22, at 12:13 a.m., indicated R19 was taken to the hospital for evaluation of behavior disturbances and family was informed of and agreed to transfer. Note also stated R19 family would pick up his belongings the next day. R19's medical record lacked evidence of a written transfer/discharge notification was provided. A list of resident hospitalizations since 6/3/22 was provided by facility administrator. R25 was hospitalized on 6/3/22, R13 was hospitalized on 6/8/22, and R26 was hospitalized on 6/9/22. When interviewed on 6/13/22, at 1:19 p.m., the	F 623	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law (Acello, 2013, p. 122) Deficient practice identified: The facility failed to provide bed hold notice at time of hospital transfer and timely notification to the State Long-Term care Ombudsman for 4/4 patients. Corrective actions(s) accomplished for those residents found to have been affected by the deficient practice: The patients listed below have discharged from the facility: R19 – Pt was in facility 3/16/22-3/29/22 R13 – Pt was in facility 5/24/22- 6/8/22 R25 – Pt was in facility 5/28/22- 6/3/22 R26 - Pt was in facility 6/1/22-6/9/22 The Dakota County Ombudsman notification process had not been implemented prior to survey.	

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F 623	Continued From page 11 director of nursing (DON) verified R19's medical record had no evidence a transfer notice was provided. The DON also stated a transfer form did not accompany the resident upon his transfer to the hospital and the ombudsman was not notified either. In addition, the DON stated the transfer notice and notice to ombudsman was not done for R25, R13, and R26. The DON stated the facility did not have a process in place for providing a written notice of transfer and/or discharge and to notify the ombudsman when residents were transferred or discharged. Facility policy titled Admission, Transfer and Discharge dated 11/28/2017 indicated: Notice of Transfer and Discharge: A. Before a resident can be transferred or discharged: 1) The resident and resident's representative(s) must be notified and the reasons for the move in writing and in a language and manner they understand. 2) A copy of the notice must be sent to a representative of the Office of the State Long-Term Care Ombudsman. 3) The reasons for the transfer or discharge are documented in the resident's medical record.	F 623	Other patients having the potential to be affected: 12 patients have been transferred to hospital from 6/12/22- 7/11/22. Systematic change(s) to ensure deficient practice does not recur: Bed hold procedure policy was reviewed updated to ensure the facility process meets the regulation. Licensed nurses and Social Service staff will be re-educated to the revised policy. Required monitoring to ensure deficient practice will not recur: 100% of hospital transfers/leaves will be audited for 3 consecutive months on-going until 100% compliance for that time. Audit findings to be reported to the QAPI committee for further review and recommendations. Person Responsible: Administrator, Social Worker	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		7/31/22

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	245618	A. BUILDING _____ B. WING _____	C 06/14/2022

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F 755	Continued From page 12 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were ordered timely and available to be administered as prescribed by the physician for 2 of 5 residents (R221, R7) who were reviewed for medication administration. Findings include: R221's admission Minimum Data Set (MDS), dated 5/22/22, identified R221 had intact	F 755	Deficient practice identified: The facility failed to ensure medications were ordered in a timely and available to be administered as prescribed by the physician for 2 patients. Immediate Action Taken: R221□s provider was notified immediately on 6/12/22, and the prescription was faxed over to the pharmacy. The	

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F 755	Continued From page 13 cognition and required extensive assistance with most activities of daily living (ADLs). Further, R221 had several medical diagnoses including severe heart disease, kidney disease, and a recent pelvic fracture. R221's care plan, dated 5/31/22, identified R221 was at risk for pain and listed several interventions to help promote comfort for R221 including routinely assessing R221 pain level and providing both non-pharmacological and pharmacological interventions. On 6/12/22 at 2:56 p.m., R221 was in her room and was interviewed by the surveyor. R221 repeatedly voiced she wanted her room door left open because she was waiting for her pain medication to arrive, and R221 was worried the nursing staff would not bring it in if the doorway was closed. R221 stated she had severe pain due to a pelvic fracture and was upset as, that morning, she only received a 2.5 milligram (mg) dose of Oxycodone instead of the 5 mg dose she requested as the supply had run out. LPN-A explained to R221 they had contacted the pharmacy and would medication was supposed to be delivered at 12:00 p.m., however, it had not yet arrived. R221 voiced her pain was now an eight (on the 0 - 10 scale) and continued voicing she wanted her pain medication soon as it takes about 30 minutes to begin working and relieving her pain. Later on 6/12/22 at 3:17 p.m. SS-A entered R221's room and stated the nurse had received the pain medication and was preparing a dose for her to take. R221 then asked if someone could help her get into bed because she thought it would help with her pain. At 3:19 p.m. registered	F 755	pharmacy was given instructions for stat delivery of medication. The medication was delivered by pharmacy that afternoon, and was administered to patient on 6/12/22. Pt was monitored and pain medication was effective. Pt was discharged 6/22/22. R7□s medication was immediately removed from the medication dispensing unit on 6/14/22 and administered. The resident was monitored and offered no further complaints. A re-fill request was called to the pharmacy and the medication arrived same day. Pt was discharged 6/21/22. Other patients having the potential to be affected: All 3 medication carts were audited for a minimum 3-day supply of medication per pt. Medications were ordered as appropriate. Systematic change(s) to ensure deficient practice does not recur: The Merwin Pharmacy policy for medication re-orders was reviewed and remains current. Licensed Nursing and TMA staff re-educated about the medication refill procedure and about the contents of, and removal of, medication from Emergency Kit and Cubex medication dispensing unit. Required monitoring to ensure deficient	

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F 755	Continued From page 14 nurse (RN)-B entered R221's room and asked R221 to rate her pain level on the zero to 10 scale. R221 responded an eight out of 10 and expressed the pain was in her right buttocks and radiated down to her foot. At 3:28 p.m. (nine minutes later), RN-B returned to R221's room and provided 5 mg of Oxycodone before assisting R221 to lie down in bed. When interviewed following these observations, on 6/12/22 at 3:40 p.m., RN-B stated they were not sure how R221 had run out of her pain medication; however, added LPN-A was the morning nurse who gave R221 her pain medication. On 6/14/22 at 7:25 a.m., LPN-A was interviewed and stated he had called the pharmacy and re-ordered the Oxycodone on 6/12/22, after he gave R221 the last Oxycodone tablet at 7:46 a.m. LPN-A stated he did not request the pharmacy to deliver the pain medication within two hours of the phone call because he knew it would be delivered sometime that day anyway. On 6/14/22 at 8:20 a.m., R221 stated she had to wait until 8:00 a.m. to get her morning Oxycodone pain medication. R221 stated after receiving her dose it took 45 min before she felt better. R221 stated she gets "very unhappy" when she had to wait a long time for her pain medication. R221 stated she will put her call light on until she gets it. When interviewed on 6/14/22 at 8:04 a.m., the dispensing pharmacist (P)-F stated the pharmacy received a fax on 6/12/22, at 4:27 a.m. for an Oxycodone refill for R221. P-F stated they preferred a 72-hour notice for all refill request to	F 755	practice will not recur: Audits will be completed 3x/week for 1 month, then 1x week for 2 months until compliance is met for a 3-month period. Audits will be reviewed at monthly QA to determine need for ongoing auditing and frequency. Person Responsible: Director of Nursing	

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F 755	Continued From page 15	F 755		

accommodate adequate preparation time. P-F stated on 6/12/22, they could have expedited the refill had LPN-A requested it and expressed as then, no other Oxycodone refill had been faxed to the pharmacy. P-F explained R221 did not have any further refills for Oxycodone from the provider, so the medical provider would have to write a new prescription before they would be able to dispense any further medication. P-F acknowledged this would cause an even further delay, since R221 only had one remaining Oxycodone dose left.

During interview on 6/14/22 9:19 a.m., R221's medical doctor (MD)-E stated R221 was able to have Oxycodone every three hours for pain which she rated at moderate or severe. MD-E stated R221 should not be running out of pain medication and added, "This has been a problem and we need to do better."

R7's face sheet, dated 6/14/22, identified R7 had intact cognition along with several medical diagnoses including heart disease, lung disease, and kidney disease. Further, R7 was currently enrolled in hospice care.

During interview on 6/14/22 at 12:56 p.m., R7 stated she had not yet received her prednisone (a steroid medication used to treat many diseases and conditions, especially those associated with inflammation) which was scheduled to be given in the morning hours. R7 was concerned and stated she needed the medication to "stay alive."

R7's Merwin LTC (long-term care) pharmacy prescription refill order form dated 6/13/22, listed R7's Prednisone refill request was the same day

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F 755	Continued From page 16 as the last dose was given on 6/13/22. When interviewed on 6/14/22 at 1:06 p.m., licensed practical nurse (LPN)-A stated R7 did not get the scheduled prednisone dose that morning, on 6/14/22, as "it was out" and had not been reordered. LPN-A stated he would contact the pharmacy this morning to get the Prednisone re-ordered. During follow-up interview on 6/14/22 at 1:31 p.m., LPN-A stated is was a problem when a resident misses any ordered medication. LPN-A stated he was not sure if prednisone would be in the emergency kit and he would have to ask his supervisor. During interview on 6/14/22, at 1:43 PM the director of nursing (DON) stated the nursing staff are expected to request a pharmacy refill three days prior to the last dose. DON stated a resident should never run out of their medication, especially a steroid or pain medication. DON stated Prednisone and Oxycodone are in the emergency supply and should have been accessed by nurses to prevent a delay in administration. A facility policy regarding when to order medication was requested but not received.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		7/31/22

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F 757	Continued From page 17 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician-ordered daily weights were collected to allow adequate monitoring of potential side effects with consumed corticosteroid medication for 1 of 5 residents (R1) reviewed for unnecessary medication use. Findings include: A Florinef Acetate information article, printed 6/14/22, identified the medication was a steroid used to reduce inflammation in the body and treat conditions where the human body does not produce enough of it's own steroids (i.e., Addison's Disease). A section labeled, "Florinef Acetate Side Effects," outlined severe side effects of the medication could include, "Swelling of feet or lower legs, rapid weight gain."	F 757	Deficient practice identified: The facility failed to ensure physician-ordered daily weights were collected to allow adequate monitoring of potential side effects with consumed corticosteroid medication for 1 patient. Immediate Action Taken: The physician order for daily weights was reinstated in R1□s electronic medical record. R1□s provider was notified immediately of failure to follow orders for daily weights. R1□s weight was collected and recorded. R1□s weight was within normal range and reported to the provider. R1 was discharged on 6/17/22. Other patients having the potential to be affected:	

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F 757	Continued From page 18 R1's Order Summary Report, printed 6/14/22, identified R1 had several medical diagnoses including orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down) and a history of repeated falls. The report identified R1 consumed several medications which included fludrocortisone acetate (Florinef) twice a day with a listed start date of 5/31/22 (R1's admission to the nursing home). R1's subsequent Physician Orders, dated 6/7/22, identified a handwritten order from the physician which read, "Daily weights dx: [diagnosis] medication monitoring for Florinef [fludrocortisone acetate]." A provided Order Audit Report, dated 6/14/22, identified this order was entered into the electronic medical record (EMR) on 6/7/22; however, the directions outlined, " ... every day and evening shift until 06/08/2022 23:59." R1's Brief Interview for Mental Status (BIMS), dated 5/31/22, identified R1 had intact cognition. On 6/14/22 at 9:06 a.m., R1 was interviewed and explained she admitted to the nursing home after being hospitalized for low-running blood pressures. R1 stated she recalled her weight being taken since she admitted to the nursing home, however, it was not being checked on a daily basis. R1 denied concerns about her weight when asked. R1's Weight Summary, dated 6/14/22, identified R1's collected and recorded weights. However, only a single weight was recorded on 6/3/22 which read, "127.4 [pounds]." Further, R1's medical record was reviewed and lacked evidence R1's weight was being collected and recorded on a daily basis in accordance with the	F 757	Facility chart audit performed immediately and no other patients on corticosteroid medication with physician-ordered daily weight monitoring were noted. Any other pt with a daily weight physician order was audited to be ensure daily weights were on EMAR. Systematic change(s) to ensure deficient practice does not recur: Licensed nurses will be re-educated re: physician ordered daily weights entry into the medical record. Physician-ordered weights will be verified in the electronic medical record by 2 nurses. Required monitoring to ensure deficient practice will not recur: To ensure that physician-ordered daily weights are transcribed correctly, audits will be completed 3x/week for 1 month, then 1x week for 2 months until compliance is met for a 3-month period. Audits will be reviewed at monthly QA to determine need for ongoing auditing and frequency. Person Responsible: Director of Nursing	

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F 757	Continued From page 19 physician order from 6/7/22. When interviewed on 6/14/22 at 9:10 a.m., nursing assistant (NA)-A stated R1 required assistance with her activities of daily living (ADLs) and used a walker with ambulation. NA-A stated R1 was alert and oriented and he was unaware of any concerns with potential weight gain or fluid build-up in her body. When questioned, NA-A stated he believed R1 was on daily weights but would have to check with the nurse to confirm. At this same time, registered nurse (RN)-B was present at the medication cart and verbally stated aloud, "I think she's [R1] a weekly weight." RN-B reviewed R1's EMR and Treatment Administration Record (TAR) and stated there were orders for a weekly weight only which was a standing order for everyone in the transitional care unit. RN-B then reviewed the handwritten physician order, dated 6/7/22, and stated she was unaware of the order and voiced, "That is weird." On 6/14/22 at 12:05 p.m., the director of nursing (DON) was interviewed. The DON reviewed the medical record and verified the ordered daily weights were not collected or recorded as the order was accidentally stopped on 6/8/22, then defaulted back to the routine weekly weights by the health unit coordinator (HUC). The DON stated the physician-ordered daily weights should have been collected to ensure appropriate medication management for R1. When interviewed on 6/14/22 at 12:44 p.m. nurse practitioner (NP)-B explained the physician who ordered the daily weights for R1 was on vacation and unavailable; however, NP-B voiced the "train of thought" with ordering such weights was to help monitor R1's volume (fluid) status given the	F 757		

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F 757	Continued From page 20 consumed steroid. R1 had a history of "significant orthostatic hypotension" and the physician team wanted to ensure she remained stable with use of the medications. Further, NP-B stated she had noticed, at times, weights were not being collected in the transitional care unit adding, "[It's] always a little bit of a struggle." A provided Medication Management policy, dated 5/16/22, identified a process for ensuring medications were safely administered and documented, however, lacked any information or guidance on how potential side effect(s) would be monitored and/or assessed. No further medication management policies were provided.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		7/31/22

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F 812	Continued From page 21 by: Based on observation, interview, and document review, the facility failed to ensure clean and sanitized dishware was dried in a manner to reduce the risk of cross contamination and food-borne illness in 1 of 1 main production kitchens. This had potential to affect all 27 residents residing in the nursing home. Findings include: During observation on 6/13/22, at 12:06 p.m., dishwasher (DW)-A transported recently cleaned various sized metallic pots, bowls, and baking pans on a portable cart to the storage shelfing. Before DW-A stacked the pots and pans on the shelf he used a burgundy-colored towel to dry off each item. Once all of the pots and pans were placed on the shelf DW-A placed the towel on his shoulder and returned to the dishwashing room. During observation on 6/13/22, at 12:13 p.m. DW-A used the same towel from his shoulder to wipe off a portable cart. DW-A then used the same towel to grab recently cleaned pots and pans off the dishwashing machine rack and wiped down each item with the same towel before placing it on the cart. DW-A then placed the towel he used for drying the pots and pan on a shelf containing clean dishes. During an observation on 6/13/22, 12:16 p.m. culinary director (CD)-A entered the kitchen from the dining room. CD-A walked into the dishwashing station and spoke to DW-A. During interview on 6/13/22, at 2:20 p.m. DW-A stated he used the towel to grab the hot pots and pans from the dishwashing rack. DW-A stated he	F 812	Deficient practice identified: The facility failed the ensure clean and sanitized dishware as dishwasher staff was observed during pots/pans with a dishtowel prior to storage. Immediate Action Taken: The culinary team were re-educated on proper cleaning and sanitizing of dishware. Other Room Doors having the potential to be affected: All residents have the potential to be impacted by the deficient practice. Systematic change(s) to ensure deficient practice does not recur: The policy and procedure for cleaning and sanitizing dishware has been reviewed and remains current. The entire culinary team will be re-educated on the policy for dishwashing. Required monitoring to ensure deficient practice will not recur: To ensure that dishes are cleaned and sanitized, audits will be completed 3x/week for 1 month, then 1x week for 2 months until compliance is met for a 3-month period. Audits will be reviewed at monthly QA to determine need for ongoing auditing and frequency.	

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F 812	Continued From page 22 knows not to dry the pots and pans off because CD-A told him not to do so. DW-A removed the towel from his shoulder to demonstrate how he would grab each item from the dishwashing machine. DW-A was not aware of the reason why items from the dishwasher required air drying. During an interview on 6/13/22, at 2:22 p.m. CD-A stated she also observed DW-A using a towel to wipe down wet pots and pans. She instructed DW-A all items washed in the dishwasher require air drying only. CD-A added at no time should a towel touch the clean pots and pans even if they are hot. DW-A should wait until the dishes cool down before grabbing. During an interview on 6/14/22, at 8:37 am dietary aide (DA)-A stated all items removed from the dishwasher require air drying only. DA-A stated the towel material could transfer to the dishes, along with dirt and bacteria. During an interview on 6/14/22, at 8:39 a.m. DA-B stated all items removed from the dishwasher require air drying only. DA-B stated they had this problem in the past with dishwashers. The facility policy Dishwashing Culinary Services dated 9/3/18, indicated pots and pans are air dried only before placing back into the storage area. Staff must avoid cross contamination and food born illness when they manage cleaned items.	F 812	Audit findings to be reported to the QAPI committee for further review and recommendations. Person Responsible: Culinary Director	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2022

CMS Certification Number (CCN): 245618

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare program.

Effective July 31, 2022 the above facility is certified for:

37 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
July 1, 2022

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: CCN: 245618
Cycle Start Date: June 14, 2022

Dear Administrator:

On June 14, 2022, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 14, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 14, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/14/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	**61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/14/2022. At the time of this survey, Walker Methodist Westwood Ridge II was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 07/11/2022

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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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Walker Methodist Westwood Ridge II is a 1-story building with a partial basement. The facility was constructed in 2012 and was determined to be of Type V(111) construction. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridors and is monitored for automatic fire department notification.

The facility has a capacity of 37 beds and had a

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K 000	Continued From page 2 census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.3.4. This deficient findingcould have a patterned impact on the residents within the facility. Findings include: On 06/14/2022 between hours of 9:00 AM and 12:00 PM, it was revealed by observation that chairs were being stored in the exit corridor located in the lower level basement. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 211	Deficient practice identified: Chairs stored in exit corridor of lower level basement Immediate Action Taken: Chairs/Equipment were removed from hallways to allow means of egress Other Room Doors having the potential to be affected: Maintenance staff will be re-educated on proper storage of equipment Systematic change(s) to ensure deficient practice does not recur: Random audits will be completed for 3 months, checking for proper equipment storage	7/31/22

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K 211	Continued From page 3	K 211	Required monitoring to ensure deficient practice will not recur: Audit findings to be reported to the QAPI committee for further review and recommendations. Person Responsible: Maintenance Supervisor	
K 221 SS=D	Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain patient sleeping room doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/14/2022 between 9:00 AM and 12:00 PM, it was revealed by observation that resident room 314 door did not latch close when tested. An interview with Facility Maintenance Director verified this deficiency finding at the time of	K 221	Deficient practice identified: Door to patient room 314 did not latch properly. Immediate Action Taken: Door latch to Room 314 repaired immediately to ensure proper closure Other Room Doors having the potential to be affected: An audit of all resident room doors were inspected for proper closure Systematic change(s) to ensure deficient	7/31/22

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K 221	Continued From page 4 discovery.	K 221	practice does not recur: Audits will be completed on all resident room door latches annually and as needed. Required monitoring to ensure deficient practice will not recur: Audit findings to be reported to the QAPI committee for further review and recommendations. Person Responsible: Maintenance Supervisor	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4 through 19.7.1.7. This deficient finding could have a widespread impact on the residents within the facility.	K 712	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited	7/31/22

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K 712	Continued From page 5 Findings include: On 06/14/2022 between hours of 9:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility did not conduct fire drills for 3rd shift for 1st, 2nd and 4th quarters. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 712	correctly. This plan of correction is submitted to meet requirements established by state and federal law (Acello, 2013, p. 122). Deficient practice identified: The facility failed to hold all required fire drills Corrective actions(s) accomplished for those residents found to have been affected by the deficient practice: N/A Corrective action taken to identify other patients having the potential to be affected by the same deficient practice: N/A Systematic change(s) to ensure deficient practice does not recur: New schedule will be developed to ensure fire drills are completed quarterly on each shift at varying times. Required monitoring to ensure deficient practice will not recur: Fire drills will be scheduled, monitored, and reported on-going as part of monthly QAPI meeting. Person Responsible: Maintenance Supervisor	