DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 15, 2023

Licensee
Walker Methodist River Heights
744 19th Avenue North
South Saint Paul, MN 55075

RE: Project Number(s) SL21583015

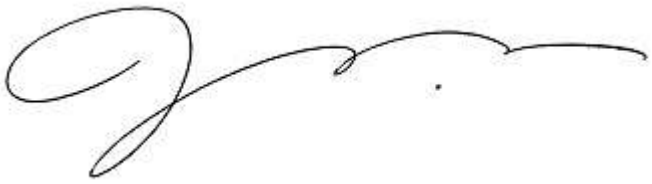
Dear Licensee:

On June 13, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 14, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

PMB

Electronically Delivered

May 22, 2023

Licensee
Walker Methodist River Heights
744 19th Avenue North
S St Paul, MN 55075

RE: Project Number(s) SL21583015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Rapid Response Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21583	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST RIVER HEIGHTS	744 19TH AVENUE NORTH S ST PAUL, MN 55075

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#21583015-0 On April 10, 2023, through April 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 49 active residents; all receiving services under the Assisted Living with Dementia Care license. On April 12, 2023, the immediacy of correction order 2070 has been removed, however non-compliance remains at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	0 510		

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0 510	Continued From page 2 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control related to perineal care for one of one resident (R9) performed by unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 11, 2023, at 8:45 a.m., ULP-B assisted another ULP perform morning cares with R9 in the bathroom. R9 stood up from the toilet and ULP-B wiped R9 from back to front then from upper thigh toward the perineal area. R9 was admitted to licensee on November 23, 2021, with diagnoses of dementia with Lewy (protein deposits) bodies, chronic kidney disease, and delirium. R9's Service Plan Agreement signed on August 24, 2022, indicated R9 received assistance with toileting, transfers, bathing, dressing, and	0 510		

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0 510	Continued From page 3 grooming. On April 11, 2023, at 11:50 a.m., director of nursing (DON)-A acknowledged that ULP-B used improper wiping techniques and would re-train staff. The licensee's Infection Control Program policy revised July 2021, indicated the licensee would provide education, including training in infection control practices, to ensure compliance with requirements as well as state and federal regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and history/symptom screening tool for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: TB HISTORY AND SYMPTOM SCREENING On April 11, 2023, at 10:13 a.m., ULP-B provided medication administration to R8. ULP-B was hired on April 27, 2021, with the previous licensee and began employment with current licensee on August 1, 2022. ULP-B's employee record lacked a current symptom screening tool under current licensee. TB BASELINE TESTING On July 27, 2022, ULP-B completed a TB blood test with indeterminate results. On August 9, 2022, ULP-B completed a chest x-ray with negative TB results. Under the	0 660		

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0 660	Continued From page 5	0 660		

comments of the results, the health provider recommended a repeat TB gold blood test in 3 months due to indeterminate result.

On April 10, 2023, at 2:13 p.m., the executive director of corporate compliance (EDCC)-F stated the licensee took possession on August 1, 2022, and required all current employees to complete TB testing and history/symptom screening.

On April 10, 2023, at 3:01 p.m., EDCC-F indicated if the TB symptom/history tool wasn't in the employee record, then it wasn't available.

On April 12, 2023, at 12:01 p.m., EDCC-F indicated he/she contacted the human resource (HR) department and stated HR did not do a follow up TB Gold blood test as recommended by the health care provider.

The Regulations for TB Control in Minnesota Health Care Settings dated July 2013, noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all HCW included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive two-step Tuberculin Skin Test (TST) or blood test.

The licensee's Tuberculosis Screening Process Team Members policy revised on September 10, 2021, indicated all employees would receive TB screening prior to employment or work. Screening consists of three components:

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0 660	Continued From page 6 - assessing for current symptoms of active TB infection, - assessing for history of TB, and - testing for the presence of TB infection either by blood test or skin test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730		

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0 730	Continued From page 7 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure records included documentation of services provided as identified in the service plan for two of four residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 730		

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0 730	Continued From page 8 R2 R2 was admitted on October 10, 2022, and had diagnoses of Alzheimer's Disease, chronic kidney disease, chronic pain syndrome, and insomnia (sleep disorder). R2's Service Plan Agreement signed on November 20, 2022, indicated services which included medication administration, assistance with toileting, bathing, dressing, grooming, housekeeping, laundry, and elopement interventions. R2's Service Checkoff List dated April 1, through April 10, 2023, lacked documentation of services: toileting, activities, escorts to meals, meal intake cueing, elopement interventions, apartment tidy, grooming assist, and bathing assistance provided on the following dates: -April 2, 3, 4, 6, and 7 at various times of the day. R3 On April 12, 2023, at 12:52 p.m., surveyor observed unlicensed personnel (ULP)-L perform toileting assistance and repositioning while in bed. R3 was admitted on February 21, 2023, and had diagnoses of thrombocythemia (low platelets), adult failure to thrive, type 2 diabetes, chronic kidney disease, and dementia without behavioral disturbance. R3's unsigned Service Plan Agreement revised on March 1, 2023, indicated R3 received services for toileting, transfers, repositioning, dressing, safety checks, escorts to meals, vision aid set up, and dining set up.	0 730		

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0 730	Continued From page 9 R3's Service Checkoff List dated April 1, through April 10, 2023, lacked documentation of services: toileting, repositioning, escorts to meals, dining set up, safety check, vision aid set up, dressing and grooming assist, and bathing assistance provided on the following dates: -April 1, 2, 5, 7, 8 and 9 at various times of the day. During interview on April 12, 2023, at 12:29 p.m., regional director of health services (RDHS)-E was unable to locate records of why the services were not documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 10 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on	0 810		

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0 810	Continued From page 11 April 11, 2023, at approximately 11:45 a.m. with Regional Director Plant Maintenance (RDPM)-J on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own	0 810		

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0 810	Continued From page 12 evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only drills were not conducted every other month and failed to provide two drills on second shift and two drills on third shift. During interview, RDPM-J verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 13 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day comprehensive reassessment using the uniform assessment tool for one of five residents (R3) as required. Additionally, licensee failed to complete a change in condition assessment when R3 admitted to hospice care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 12, 2023, at 12:52 p.m., surveyor observed unlicensed personnel (ULP)-L and hospice ULP perform brief change and repositioning to R3 while in bed. 14-DAY ASSESSMENT R3 admitted to licensee on February 21, 2023. R3's unsigned Service Plan Agreement revised	01620		

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01620	Continued From page 14 on March 1, 2023, indicated R3 received services for medication administration, toileting, transfers, repositioning, laundry, and housekeeping. R3's record included a 14-Day Assessment dated March 7, 2023, which indicated R3 required assistance with medication and treatment administration, hospice, adaptive equipment (walker, electric bed, wheelchair, Broda chair (large, padded reclining wheelchair) and shower chair) but lacked the following areas of the uniform assessment tool: - resident's personal lifestyle preferences; - activities of daily living; - physical health status; - emotional and mental health conditions; - cognition; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences; - list of treatments; - risk indicators; and -who has decision making authority. CHANGE IN CONDITION R3's Progress Notes dated March 1, 2023, indicated R3 was admitted to hospice with changes to medications, and ordered a Hoyer (full body lift), over the bed table, Broda chair, and incontinent products. R3's medical record lacked a full RN assessment. On April 12, 2023, at 9:30 a.m., regional director of health services (RDHS)-E indicated if the nursing staff thought there was a change in condition during the 14-day assessment, the nursing staff would complete a full RN comprehensive assessment. RDHS-E confirmed	01620		

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01620	Continued From page 15 there were no additional assessments completed for R3. On April 12, 2023, at 11:48 a.m., RDHS-E stated the 14-day assessment which lacked the above information was standard unless there was a change in condition or changes in the service plan. On April 12, 2023, at 1:54 p.m., RDHS-E expected a full RN comprehensive assessment should have been completed when R3 admitted to hospice. The licensee's Resident Assessments and Service Agreements policy revised on December 1, 2022, indicated a 14-day reassessment and monitoring must be conducted no more than 14 calendar days after admission/initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 16 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for three of five residents (R6, R7, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R6 On April 11, 2023, at 10:23 a.m., unlicensed personnel (ULP)-I administered Tylenol 325 milligram (mg) tablet-two tablets to R6. The Tylenol was scheduled to be given at noon. R6 was admitted to licensee on November 16, 2021, with diagnoses of Alzheimer's Disease, type II diabetes, and anxiety. R6's Service Plan Agreement last revised on January 25, 2023, indicated R6 received assistance with dressing, grooming,	01760		

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01760	Continued From page 17 housekeeping, laundry, and medication administration. R6's physician orders signed on September 7, 2022, indicated to give Tylenol 325 mg tablet-two tablets upon rising, noon and at bedtime. R7 On April 11, 2023, at 10:20 a.m., ULP-I administered Tylenol 500 mg tablet-two tablets to R7. The Tylenol was scheduled to be given at noon. R7 was admitted to licensee on December 1, 2020, with diagnoses of Alzheimer's Disease, chronic obstructive pulmonary disease (COPD), and chronic gout (inflammatory arthritis) of the left ankle and foot. R7's Service Plan Agreement last revised on March 6, 2023, indicated R7 received assistance with dressing, grooming, toileting, transfers, safety checks, oxygen, and medication administration. R7's physician orders signed on December 5, 2022, indicated to give Tylenol 500 mg tablet-two tablets by mouth upon rising, noon and bedtime. R8 During observation and interview on April 11, 2023, at 10:13 a.m., ULP-B was observed to administer scheduled Tylenol 500 mg tablet- two tablets by mouth twice a day to R8. The Tylenol was scheduled to be given at 12:00 p.m. Surveyor asked the time frame of when medications could be given, ULP-B indicated if it showed up on the computer screen, they are allowed to give it despite it being more than an hour before the scheduled time.	01760		

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01760	Continued From page 18 R8 was admitted to licensee on April 1, 2018, with diagnoses of mild cognitive impairment, osteoporosis, major depressive disorder, and disorientation. R8's Service Plan Agreement signed on September 1, 2022, indicated R8 received assistance with bathing, dressing, grooming, toileting, and medication administration. R8's physician orders signed on September 7, 2022, indicated to give Tylenol 500 mg tablet-two tablets by mouth twice a day upon rising and at noon. On April 11, 2023, at 11:50 a.m., director of nursing (DON)-A checked the medication administration record (MAR) and indicated the Tylenol should not have been given that early for R6, R7, and R8. DON-A stated ULPs were not trained to give medications that early despite it showing on their service task. The licensee's Medication Management Services revised on September 29, 2022, indicated staff must document the reason why the administration was not completed and document any follow up procedures that were provided to meet the resident's needs, when medication was not administered as prescribed and in compliance with the resident's medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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02040	Continued From page 19	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted April 11, 2023, at approximately 11:50 a.m. with	02040		

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02040	Continued From page 20 Regional Director Plant Maintenance (RDPM)-J on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, DM/PM-J stated the facility had conducted this assessment but was not able to provide documentation or locate the assessment at the time of survey. RDPM-J verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an awake person was physically present in a secured dementia care unit, 24 hours a day, seven days a week who was responsible for responding to	02070		

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02070	Continued From page 21	02070		

requests of residents for assistance in a secured area. This had the potential to affect all residents in the secured dementia care unit.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On April 10, 2023, during entrance conference at 10:30 a.m., the licensee indicated two people were staffed on the overnight shift. One unlicensed personnel (ULP) was scheduled to work in the locked memory care unit and the other ULP was scheduled to work in the assisted living units (three floors). The licensee also indicated the overnight shift started at 10:00 p.m. until 6:00 a.m.

On April 10, 2023, during a facility tour at 11:45 a.m., the surveyor observed four levels. The lowest level had the locked memory care unit. Levels two, three and four had assisted living resident apartments.

During interview with ULP-B and ULP-I on April 11, 2023, at 9:45 a.m., both stated the licensee staffed two ULPs during the night shift, one in memory care and one in assisted living. ULP-B indicated the licensee was working on hiring another staff person to be a "float" to assist both memory care and assisted living so. ULP-B also indicated if the staff person working in assisted

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02070	Continued From page 22 living needed help, the staff person from memory care would come up to assist leaving memory care unattended. On April 11, 2023, at 10:18 a.m., ULP-B indicated staff were trained to use two staff members for all Hoyer (manual machine lift that raises a resident while in a full body sling) transfers. R3 R3 admitted to the licensee's assisted living unit on February 21, 2023, with diagnoses of thrombocytopenia (low platelets), adult failure to thrive, muscle weakness, repeated falls, and dementia without behavioral disturbance. R3's Service Plan Agreement last updated on March 21, 2023, indicated R3 received the following services: bathing with assist of two staff, meal set up, blood glucose checks, assist of two staff for all Hoyer transfers, assist of two to reposition in bed, assist of two to toilet with Hoyer lift, and assist of one with toileting, but may require transfer assistance, laundry, and safety checks. R3's Level of Care Assessment signed by a registered nurse on February 21, 2023, indicated R3 required physical assistance of two staff for repositioning in bed (three times a day or night). The assessment also indicated R3 required physical assistance of two staff for Hoyer three times a day (did not indicate time). Additionally, the assessment indicated R3 required physical assistance of two staff for toileting and/or continence care. R3's Resident Services Usage dated April 1 through April 11, 2023, indicated "Repositioning: 2-person assist" was provided by two staff on the	02070		

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02070	Continued From page 23 following dates/times: -April 3, 2023, at 5:38 a.m., -April 4, 2023, at 11:44 p.m., -April 5, 2023, at 5:58 a.m., -April 7, 2023, at 1:38 a.m., -April 8, 2023, at 5:36 a.m., and -April 9, 2023, at 5:17 a.m. During interview with ULP-G and ULP-H while working in assisted living on April 11, 2023, at 11:42 a.m., both stated R3 required two people to perform toileting cares while in bed, including overnight, which means the memory care staff person would come up to help the assisted living staff person leaving memory care left unattended. They also stated they were required to have two people for all Hoyer transfers. The licensee's posted "April 9th-15th" staff schedule indicated two ULPs were scheduled to work overnight daily. During interview on April 11, 2023, at 2:30 p.m., director of nursing (DON)-A acknowledged R3's two staff assistance on both the assessment and the service agreement. DON-A stated he/she did not handle the staff schedule and wasn't sure how many were staffed on the night shift. DON-A stated it wasn't brought to his/her attention there wasn't enough staff to meet the needs of R3 and keep memory care staffed at all times. DON-A stated staff notify him/her of issues, but he/she hasn't heard of any since R3 was admitted. The licensee's Assisted Living Direct-Care Daily Staff Schedules policy last revised on July 14, 2021, indicated the licensee would create a daily staffing schedule to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident's	02070		

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WALKER METHODIST RIVER HEIGHTS	744 19TH AVENUE NORTH S ST PAUL, MN 55075

(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
02070	Continued From page 24 assessments and service plans on a 24-hour per day basis, seven days per week. Additionally, it indicated the memory care unit must always have at least one staff member available and awake at all times, 24 hours a day, 7 days a week. The licensee's Ambulation and Transfers: Physical Assistance and/or Mechanical Devices policy last revised on July 14, 2021, indicated mechanical lift devices (such as Hoyer lift) require a minimum of two staff to transfer a resident. No further information provided. TIME PERIOD FOR CORRECTION: Immediate On April 12, 2023, the immediacy of correction order 2070 has been removed as confirmed by surveyor and supervisor review, however non-compliance remains at a scope and level of I.	02070		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/10/23*
Time: 14:23:17
Report: 1021231085

Food and Beverage Establishment Inspection Report

Location:
Walker Methodist River Heights
744 19th Ave N
South St. Paul, MN55075
Dakota County, 19

Establishment Info:
ID #: N021583
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER BLADE CONTAINS DRIED FOOD DEBRIS. STAFF SENT THE CAN OPENER TO THE DISH MACHINE DURING INSPECTION. CORRECTED ON-SITE. CLEAN AND SANITIZE THE CAN OPENER AFTER EACH USE.

Comply By: 04/10/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

THE CERTIFIED FOOD PROTECTION MANAGER (CFPM) CERTIFICATE FOR JODI JONES IS CURRENTLY EXPIRED. INFORMATION ON HOW TO RENEW THE CFPM CERTIFICATE SENT WITH REPORT.

Comply By: 05/10/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

THE SAFETY GUARD OF THE COMMERCIAL MIXER CONTAINS ACCUMULATION OF DRIED BATTER SPLATTER. CLEAN AND SANITIZE MIXER AFTER EACH USE. THE WALK-IN FREEZER FLOOR CONTAINS DRIED FOOD DEBRIS UNDER THE STORAGE SHELVES. CLEAN AND MAINTAIN CLEAN.

Comply By: 04/14/23

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

THE ICE MACHINE CONTAINS ACCUMULATION OF DEBRIS AND PINK BIOFILM RESIDUE AROUND THE ICE MOLD. CLEAN AND SANITIZE ICE MACHINE.

Comply By: 04/10/23

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

THE INTERIOR CAVITY OF THE MEMORY CARE MICROWAVE CONTAINS SPLASHING OF DRIED FOOD DEBRIS. CLEAN AND SANITIZE MICROWAVE.

Comply By: 04/12/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING SINKS IN THE DINING AREA AND IN THE MEMORY CARE KITCHEN ARE MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 04/14/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANI BUCKET, KITCHEN
Violation Issued: No

Final Utensil Surface Temp: = at 163 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: SLICED TOMATO - NORLAKE PREP COOLER, COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SLICED HAM - NORLAKE PREP COOLER, COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CUT LETTUCE - NORLAKE PREP COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 177 Degrees Fahrenheit - Location: TOMATO SOUP - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - NORLAKE TWO DOOR COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CHICKEN SOUP BASE - NORLAKE TWO DOOR COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: HARD BOILED EGGS - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: MILK - WALK-IN COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: TOMATO SOUP - HOT WELLS, MEMORY CARE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: GREEN BEANS - HOT WELLS, MEMORY CARE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - MEMORY CARE REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CUT MELON - NORLAKE UPRIGHT COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	5

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH CHEF MANAGER, JODI JONES, INTERIM ADMINISTRATOR, RON DONACIK, AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ANNA BOHNEN.

PER CONVERSATION WITH JODI, ALL FOOD IS FOR SAME DAY SERVICE. NOR LEFTOVERS

ARE KEPT.

DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING. ESTABLISHMENT HAS AN MDH EMPLOYEE ILLNESS LOG.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021231085 of 04/10/23.

Certified Food Protection Manager: JODI M. JONES

Certification Number: FM86217 Expires: 02/02/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

JODI JONES
CHEF MANAGER

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us